DOCTOR OF PHILOSOPHY

A qualitative study examining the Scottish legislative framework dealing with mental health, incapacity and adults at risk of harm, from the perspective of professional staff undertaking related social work functions

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DECLARATION

I confirm that I am the author of this thesis; and that, unless otherwise stated, all references cited have been consulted by me personally; that the work, of which the thesis is a record has been undertaken solely by me, and it has not been previously accepted for a higher degree.

I can further confirm that for the purpose of confidentiality all areas and individuals have been rendered anonymous and identifying details have been removed.

Signed

Iain Fisk

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ABSTRACT

This qualitative study examines the Scottish legal framework, which deals with incapacity, mental health and adult protection from the perspective of professional staff exercising related social work functions. Social work departments have a lead role in respect of the three main Acts. As a social worker employed in one of these authorities, I had identified a gap in research, reflecting the views of this group of staff. I was aware of increasing concerns about the legislation and wide-spread variation in its use across Scotland. Furthermore, court cases at Scottish and international levels have increasingly challenged legal authority to take decisions or limit the personal freedom of individuals experiencing mental disorder or who lack mental capacity.

Literature reviewed for the purpose of this study examines the origins of diagnosis and treatment and developments in mental health law in Scotland and western society. Literature and research relating to Scotland is limited and very little reflects the views of those exercising social work functions under this framework.

The primary data for this study was collected through eight focus groups across three local authority areas involving 48 participants. These included eleven nurses of whom seven were employed by NHS, the remaining 37 were social workers. All were engaged in assessing and delivering community care services. Each group answered a set of open questions and specific questions relating to three case studies. These questions were designed to better understand the credibility of the law from the perspective of participants and how they interpreted the law. The data was analysed using a thematic approach.

In terms of credibility, participants broadly supported the intentions of the law, believing it had improved user and carer involvement and increased respect for human rights. Many believed the law reached out to hidden groups and improved inter-agency cooperation. Concerns related to bureaucratic processes, inappropriate and inconsistent use of law, poor risk management, lack of resources to support implementation and increased political and managerial interference. Ethical concerns were raised in relation to use of investigative powers, attitudes to those misusing substances and increasing blame culture. Differing interpretations of law were evident across the groups and, by their account, in other professional groupings. Areas of difference included assessing capacity, diagnosing mental disorder, thresholds for intervention, terminology and responses to deprivation of liberty.

Recommendations arising from this thesis identify a need for further research into understanding others' perspectives on this framework, inappropriate use of civil and criminal procedures and identifying ideal service structures to support the legislation. Practice recommendations call for multi-agency training utilising an integrated approach to the legislative framework, review of roles relating to this framework and also entreats managers and government bodies to reflect on why participants might perceive an increase in blame culture. Finally, in terms of legal reform legislators should consider widening the range of professionals who can assess capacity and review the principles across all three Acts. Consideration should also be given, as to how to better involve groups of professionals such as these, who work with the law on a day-to-day basis, in legal reform.

GLOSSARY

ASW: Approved Social Worker

CLDN: Community Learning Disability Nurse

CMHT: Community Mental Health Team

CPA: Care Programme Approach

CPN: Community Psychiatric Nurse

CQC: Care Quality Commission

CTO: Compulsory Treatment Order (2003 Act)

DSM: Diagnostic and Statistical Manual of Mental Disorders

ECHR: European Convention of Human Rights

ECT: Electro-Convulsive Therapy

ECtHR: European Court of Human Rights

MDO: Mentally Disordered Offender

MHO: Mental Health Officer

MHTS: Mental Health Tribunal for Scotland

MWC: Mental Welfare Commission

OPG: Office of the Public Guardian

Proxy: Refers to persons exercising functions on behalf of adults under the 2000 Act

RMA: Risk Management Authority

RMO: Responsible Medical Officer

SSRI: Selective Serotonin Reuptake Inhibitor

STDC: Short Term Detention Certificate (2003Act)

SWIA: Social Work Inspection Agency

Chapter 1

Introduction

1.0 INTRODUCTION

The title of this thesis is as follows:

A qualitative study examining the Scottish legislative framework dealing with mental health, incapacity and adults at risk of harm, from the perspective of professional staff undertaking related social work functions

Throughout this thesis I use the first person, to aid clarity of expression and to be explicit about the rationale for methodological choices I have personally made.

1.1 Background/Context

The legislation referred to primarily comprises:

Adults with Incapacity (Scotland) Act 2000 (the 2000 Act)

Mental Health (Care and Treatment) (Scotland) Act 2003 (the 2003 Act)

Adult Support and Protection (Scotland) Act 2007 (the 2007 Act)

These Acts, implemented between April 2001 and October 2008, were intended as a coherent framework, a so-called 'three-pronged approach' to dealing with the affairs of adults in need of support and protection, due to mental disorder or some other vulnerability (Scottish Government 2011a). Amendments to the Social Work (Scotland) Act 1968 and the Criminal Procedures (Scotland) Act 1995 also impact on the use of these pieces of legislation.

The groups predominantly affected by this legislation are those with 'mental disorder' in terms of s328 of the 2003 Act, namely people with personality disorder, learning disability or mental illness. The Code of Practice (Scottish Executive 2005d) clarifies

that mental illness includes schizophrenia, depression, anxiety related disorders, organic brain disorders and other cognitive impairments, resulting from long-term illness such as Huntington's disease and multiple sclerosis. Where the term 'mental disorder' is used in this study it will be based on this 2003 Act definition.

To understand the context, it is essential to consider what were seen to be the limitations of the existing legislative framework and how this new framework has evolved. This will be closely examined in the review of literature but the following brief summary of the new framework helps to set the context for this thesis. All three Acts include guiding principles, which must be taken into account by those discharging related functions.

1.1.1 The 2000 Act

The Scottish Law Commission's 'Report on Incapable Adults' (SLC 1995) brought together a wide range of stakeholders to examine the need for reforming law in relation to capacity issues and associated risk management. The term 'incapable adults' was quickly translated into the more politically acceptable 'adults with incapacity' and ultimately the findings of the report were accepted, resulting in the 2000 Act. Section 1(6) of the 2000 Act clarifies that incapacity should be defined according to the inability to make, understand, act on, communicate or remember decisions, either due to mental disorder or inability to communicate, so is thus decision specific rather than 'all or nothing'. This Act empowers others to provide care and support to adults, incapable of protecting their own welfare or financial situation and obliges the local authority to intervene where necessary (s10, s53, s57). The 2000 Act also sought to deal with medical consent issues, previously managed by legislation originating in 1585 (Ward 1990). A significantly redefined

version of Guardianship was imported from the Mental Health (Scotland) Act 1984 (the 1984 Act) and The Office of the Public Guardian (OPG) was established to oversee financial interventions.

1.1.2 The 2003 Act

The Millan Committee was established to review the 1984 Act in response to wide-ranging concerns about its operation, specifically lack of community focus, poor participation and limited recognition of human rights. High rates of mental disorder amongst those subject to criminal proceedings and the role of the Sheriff Court also needed to be addressed. The Committee's report (Scottish Executive 2001c), subject to extensive consultation, led to the establishment of the 2003 Act.

The 2003 Act introduced Mental Health Tribunals to replace and extend the Sheriff Court's role in decision-making. named person arrangements were put in place to address issues about the involvement of relatives and a range of measures to better involve the service user were introduced, including Advance Statements, access to advocacy and rights to attend tribunals. The role of the MHO was also considerably enhanced, particularly in relation to criminal procedures.

1.1.3 The 2007 Act and its limitations

Alongside these reforms a Vulnerable Adults Bill was under active consideration (SLC 1997), though it was the last to be enacted, and was subject to considerable amendment, not least replacing the term 'vulnerable adult' in favour of 'adult at risk of harm'. Widely seen to lack 'teeth' (MacKay et al 2011), the key measures (protection orders) enabling access, assessment and removal of persons at risk are rarely used. Banning orders have been used more but are limited to specified premises and as with other powers the adult's consent is required, unless

demonstrably under ‘undue pressure’ not to comply (Ekosgen 2013). The impact an adult’s lack of capacity may have on the practicality, or indeed the desirability, of imposing such orders is much debated. The 2007 Act has however, become a ‘gateway’ to other legislation and the principal activity relates to inquiries and investigations, rather than protection orders (Ekosgen 2013)

1.1.4 Lead roles

Those discharging functions on behalf of local authorities are given leading roles across the framework. The 2000 Act requires local authorities to apply for guardianship where necessary, and in all cases where welfare guardianship is sought, to report on the suitability of guardians and appropriateness of the order (s57). All three Acts place local authorities under a duty to inquire. Regulations clarify that MHOs, who have specific roles under the 2000 and 2003 Acts, must be social workers with at least two years post-qualifying experience and have undertaken accredited training focusing on mental health care and treatment, law and report writing (Scottish Executive 2005d). In a third of its 333 sections, the 2003 Act identifies a role for MHOs, including seeking and consenting to detention or compulsion. Under the 2000 Act, MHOs report on the appropriateness of orders and suitability of guardians. Those discharging local authority functions have roles under the 2000 and 2007 Acts in terms of assessment and investigation. The earlier part of the review of literature for this thesis briefly examines the developing role of social work in the area of mental disorder. The latter part of the review discusses the limited research and literature relating to the social work role under this legislative framework.

Psychiatrists are assigned a key role in assessing capacity under the 2000 Act (s57(3)) and in many aspects of the 2003 Act. For reasons explained later, it was decided not to seek the views of psychiatrists for this thesis, however, their perspective and the ways in which their role has developed will be discussed in the review of literature and from the perspective of participants in this study.

1.1.5 Use of the Acts

Examining use of this legislation raises some interesting questions about the variable manner in which this framework is applied across the country. The following statistical data, taken from MWC monitoring reports (MWC 2009a, 2010a, 2010d, 2012a, 2012b, 2012c, 2014a, 2014g, 2015a, 2015b) demonstrates significant regional variation in use of the 2000 and 2003 Acts.

Under the 2000 Act in 2009/10, granted welfare guardianship applications numbered 21 per 100 thousand people in Edinburgh as opposed to 39 per 100 thousand in Glasgow. Semi-rural areas show similar differences, for example in the same year Perth and Kinross at 47 and Stirling at 14 per 100 thousand. This oversimplifies the issue however, as some areas' rates have varied over time. For example, North Lanarkshire recorded 22 per 100 thousand Guardianships in 2008/9, rising to 63 in 2014/15 and Glasgow has risen from 41 to 74 over the same period. Whilst most areas have shown substantial year on year per capita increases, some areas have remained static (Angus) and others have shown falls (Perth and Kinross). The MWC has been consistently critical in its annual reports, about overuse of guardianship and wide local variance (MWC 2014a).

In 2011/12 under the 2003 Act, 84 per 100 thousand people in Edinburgh were subject to Short Term Detention Certificates (STDC), yet in the same period in Glasgow the rate was around 40% higher at 110 per 100 thousand. Differences were also evident between rural areas for STDCs in the same year, for example Angus recorded 38, Aberdeenshire 50 and Borders 54 (all per 100 thousand) yet demographically these are similar areas. During 2011/12 NHS Tayside residents were twice as likely as NHS Ayrshire and Arran residents to be subject to a compulsory treatment order (CTO) and there were 50% more CTOs held in Glasgow than in Edinburgh (MWC 2012). There is less year on year variation with regard to the 2003 Act though there are some anomalies. For example, NHS Highland ranked eighth in the table of 15 NHS Boards for per capita numbers of CTOs at the beginning of 2009 with 44 per 100 thousand and rose to joint first place in 2012 with 65 per 100 thousand.

Unfortunately, there is no central database for statistics relating to the 2007 Act, consequently very little accurate statistical information is available. The Ekosgen (2013) report certainly suggests similar local variation and that the predominant activity apart from inquiries and investigations, apparently numbering 1650 between 2010 and 2012, is in relation to banning orders, numbering 137 in the same period. Preston-Shoot and Cornish (2014) concur that assessment or removal orders are rarely used and that it is investigative powers which are most commonly used.

1.2 Rationale

As the author of this thesis it is important to acknowledge my keen interest in this subject area from the outset. Now in higher education, I practised as an MHO between 1995 and 2010 and took a lead role for my local authority in developing policy and procedure around all these Acts. I was routinely asked to provide advice, and sometimes adjudicate, on issues relating to application of this legal framework. In so doing I had regular contact with others holding similar positions in other local authorities, and from time to time with the OPG, MWC and Scottish Government. As a representative of my local authority I sat on several local and national bodies including: the Association of Directors of Social Work mental health sub-group and the local NHS Board Joint Implementation team for the 2003 Act. I was appointed as a General Member on the Mental Health Tribunal for Scotland (MHTS) in 2005 and continue to fulfil this role. This experience has provided me with insight into a wide range of perspectives held on this legislative framework and the very different patterns of usage across the country.

Denzin (1989, in Johnson, Onwuegbuzie and Turner 2007) asserts that researchers bring their own preconceptions and interpretations no matter what efforts are made to mitigate this, so I will briefly outline some of these here. I believe important benefits of guardianship may be undermined due to perceptions around the time involved and the expense of making applications. I am also concerned that community-based compulsory treatment orders may be over-used to deprive people of their liberty to refuse treatment. I am aware many practitioners with lead responsibility for care packages are confronted with significant difficulties in working alongside medical colleagues. In my experience and that of others I spoke to,

managers were not inclined to engage in the associated complexities of using legislation and preferred simple solutions to caring for and treating people. In itself this does not particularly concern me, as I believe we should seek the minimum restriction possible in line with social work values and principles of the Acts. However, the Acts are designed to protect rights and enable considered intervention, so moves to circumvent or undermine the legislation are concerning. I am also aware that there are many who are critical of the input of psychiatry, whether in assessing capacity or deciding on compulsion. However, I believe many psychiatrists bring a very community focussed view to considering issues of care and treatment and that behaviours which undermine the law, occur across the professional spectrum. This is a highly complex area and this research seeks to shed light on differing perspectives and relationships affected by this legislation.

NHS staff, police, voluntary agencies, solicitors, regulatory bodies, accountants and private individuals all potentially have responsibilities under these Acts. However, I sought to better understand the perspective of those discharging local authority functions as they have a lead role in the majority of interventions. Inconsistencies in the application of the law, outlined in the introduction, initially led me to question how far this was influenced by poor understanding of the law and the complex interaction between different professionals. However, I recognised that flexibility in applying the law may be desirable given the sensitive and complex issues that such legislation seeks to address. The review of literature in Chapter 2 highlights differing professional perspectives between health and social work professions, yet the legislative framework requires there to be close cooperation between the two professional groups, not least to ensure such applications proceed within the

appropriate timescales. Anticipating the potential for poor communication and professional differences, the Acts try to manage this by compelling and encouraging joint working, for example section 5 of the 2007 Act places a duty of cooperation on local authorities and health boards.

The statute and related commentary demonstrate that social work has limited power to act independently, so the perspectives of those carrying out local authority functions under the Acts, as to the nature and consequences of the interaction between health and social work, should be of great interest. Notwithstanding local variation, other concerns have been expressed regarding this legislation for example about cumbersome application processes, particularly Guardianship under the 2000 Act (OPG 2011; Patrick 2008; Killeenet al 2004). Given that this framework was implemented and has been operating for some time in an economic climate of austerity, lack of resources should also be considered when examining the way the law has been implemented. I was interested in how far the extensive codes of practice were used, from where professionals sought advice and, given the emphasis on risk within the Acts, I sought to understand whether practitioners believed measures in the Act facilitated risk management. This legal framework is seen as an international exemplar, very much in the vanguard of progressive mental health and incapacity legislation (Campbell and Davidson 2009; Stevenson, Ryan and Anderson 2009; Atkinson 2006). I was therefore interested in whether those discharging social work functions shared that view or if they believed there were areas which were yet to be addressed by legislation or guidance.

Although this thesis was commenced in October 2007 the same issues still have relevance. In a press release to accompany the launch of the 2013/14 monitoring reports, the Chief Executive of the MWC commented that MHO services are under tremendous pressure in trying to meet the demands of applying the legislation and noted that “One trend that appears in both of these reports is the wide variation across Scotland …Some of that variation is very difficult to explain, and a priority for the Commission now is to look at how different practice affects the outcomes for people with mental health problems and learning disabilities” (MWC 2014). There is continuing debate about the need for amendments to this framework to take account of the broader issues identified in the earlier part of this section, particularly perceived overuse of guardianship (SLC 2014; Scottish Government 2009b). Whilst this research cannot provide an objective evaluation of the legislative framework, I believe that gaining an understanding of the credibility of the framework from participants’ perspective and how they interpret it on a day-to-day basis would help identify issues of importance to practitioners. The absence of any substantial research into the role of local authority as a lead agency provides a unique opportunity for this research to draw out rich areas for debate and future research, which potentially benefits those subject to the framework. Because of my extensive background in the area and the rigorous attempts I have made to maintain independence, I am convinced that this research will be of great interest to a wide variety of stakeholders and that my own experience in this field will lend credibility to the findings.

1.3 Aims and Objectives

The principal purpose of this study is to establish the perceptions of professionals undertaking local authority social work functions in relation to the suite of legislation under consideration.

Two key aims have been identified, firstly establishing the credibility of the legal framework from the perspective of participants and secondly gaining insight into how they interpret the law in practice. To achieve these aims, several objectives are set out below

To establish the credibility of the legal framework for participants, objectives will include:

- Beliefs about efficacy risks and outcomes
- Beliefs about the ethical and evidence base of the law

To gain insight into how participants interpret the law, objectives will include:

- Understanding how the law is used, including any local variations
- Principal sources of knowledge about the legal framework
- Factors which impact on the ability to use law
- The impact of resources on use of the law

The conclusions section will bring together themes identified in the findings and discussion sections, make links to these aims and objectives and provide a comprehensive understanding of issues facing professionals carrying out social work functions in relation to this legislative framework from the perspective of this group of participants.

Chapter 2

Chapter 2

Review of literature

2.0 REVIEW OF LITERATURE

2.1 Introductory comments and methodology

This review of literature explores the knowledge base that has influenced the development and operation of the Scottish legislative framework relating to mental health, incapacity and adult protection. This thesis was commenced in late 2007, at which point the 2000 and 2003 Acts were fully enacted and the 2007 Act, enacted in October 2008, had just received Royal Assent. Consequently, the available literature in relation to these Acts and their interaction was limited. Whilst this continues to be the case, new literature from 2008 to 2016, has been integrated into this review, for example empirical research relating to named person and adult protection legislation.

2.1.1 Structure of this review

This legal framework is primarily concerned with the imposition of treatment, in its broadest sense, on people who are deemed to lack capacity, or are unable to recognise the need for such treatment. To set the context and provide insight into perceptions of academics and practitioners about definitions of mental disorder and problems associated with diagnosis, the introductory section of this review provides an overview of the debates around mental illness, incapacity and ‘madness’ from a historical and current perspective. There is a substantial body of literature related to these themes, so this section is necessarily selective, the criteria for which will be discussed later. The review goes on to look at complex issues about treatment for mental disorder, including medication, psychological therapies and social interventions. An awareness of the key issues around treatment, both historic and current, is helpful when considering the evidence base for, and operation of, the

legal framework. Given that psychiatrists and social work services are at the core when considering compulsory interventions, the review goes on to examine historical reasons for the involvement of these professions in treating mental disorder and dealing with incapacity. The next section explores risk and the rationale and justification for the use of compulsory measures, as these are likely to be important to those charged with implementing the law (Bean 2001). The next major section briefly considers the influence of inquiries on the development of mental health law and then examines all inquiries led by the Mental Welfare Commission (MWC) between 2006 and 2016. In the absence of substantial independent research into use of the legislative framework in Scotland, these inquiries provide a useful insight into the operation of this framework. The final part of the review examines literature relating to drivers for this legislative framework, International perspectives and use of legislation since its inception. Little research is available on the social work role in mental illness from the perspective of those exercising social work functions (Campbell et al 2006), particularly in Scotland. A key part of the rationale for this thesis is to provide a better understanding of these practitioners' perspectives on the Scottish legal framework.

2.1.2 Methodology and associated search strategy

The review of literature was based on wide-ranging searches including ASSIA, Web of Knowledge, Scopus and Westlaw. Appendix 6 provides a full list of search terms utilised and databases accessed. Sources from literature reviews and academic papers have also been utilised, whereby one article has provided references to other relevant material, similar to a 'snowball' sampling approach for engaging 'difficult to reach' participants, whereby one participant identifies others who may be interested (Bryman 2008). Applying this approach to a literature search helps identify relevant

literature which is not readily accessible. Remaining materials have been sourced through personal knowledge or others' recommendations.

2.1.2.1 Inclusion criteria for literature

Literature is largely confined to developed countries with similar cultural and legal approaches to mental disorder as Scotland, specifically Northern Europe, USA, Canada and Australia. This is mostly commentary by prominent academics, but where empirical research has been available this is highlighted. Literature from the mid-1800s is utilised in the first section as it brings to life early experiences of asylums. Other older texts help to set the historic context for the study including literature relating to the developing medical and social work roles. The later sections utilise more recent texts to explore the background to the current legislative framework. These sources, drawn from the 1990s onwards, often research-based, comment on interventions, similar to those under the Scottish legal framework. Mostly this literature was drawn from books, peer reviewed journals or government documents. The final sections include academic texts which offer critical analysis, or commentary, on empirical studies relating to the new legislative framework in Scotland. Although a few studies appraise stakeholder's views, including those carrying out social work functions, none primarily target this group and few explore the legal framework from their perspective. Official government documents, such as codes of practice, are included as these provide authoritative direction on how the framework should be used. Although the paucity of research into the Scottish legal framework is a significant limitation, the literature provides a baseline for understanding the impact of the current legislative framework, in relation to this thesis.

2.1.2.2 Exclusion criteria

A number of available texts seek to explain the legislative framework in Scotland for practitioners' benefit. Although some of these texts do make interesting points and include some 'interpretive' elements these are, for the most part, descriptive guides to the law, so these are excluded, except where brief inclusion of some content illustrates either the range of perspectives or occasionally flawed interpretation of the law.

Whilst comparisons with legal frameworks elsewhere are useful, the purpose of this study is not to compare legal structures, but to explore professionals' perceptions of the Scottish legal framework. For this reason, detailed comparisons with law elsewhere and associated commentary are excluded. Information directly derived from lobby groups or those seeking to promote particular interests, for example, recovery, advocacy or diagnosis-based groups, is also excluded. Whilst these sources provide interesting perspectives these are not necessarily based on empirical research. In this study the interest group is those providing social work services and their perspectives about Scottish legislation, so where appropriate literature highlighting social work perspectives has been included. Pilgrim and Rogers' (2009) observations on the influence of interest groups on use of mental health law, highlight the importance of being clear about whose perspective is under consideration. They refer to the varying influence of professionals, politicians, planners and community groups on the direction of law and policy, particularly emphasising the dominance of medical professionals. Consequences of excluding some of these potential sources of literature, such as user perspectives or wider comparisons with other systems, are considered in the limitations section of the methodology Chapter.

2.2 Defining and diagnosing mental disorder

2.2.1 Legal definition of mental disorder

Terminology used in the 2000 Act and its predecessors, for example tutors-at-law and the concept of ‘guardian’, was formalised in law in Scotland in 1585, however, these ideas had existed in Scots law long before this. Early language used to describe mental disorder would now be considered to be prejudicial, for example ‘the furious’, ‘prodigal’ and ‘idiot’ (Ward 1990). Over centuries terminology, and for that matter diagnoses, have fluctuated depending on trends in diagnosis, in turn dependent on societies’ views of those with mental disorder.

For the purpose of this study, the 2003 Act definition for mental disorder (s328), outlined in the rationale, will be used. This underpins the criteria for legal intervention, as diagnosis of mental disorder based on this definition, is central to all three Acts. However, mental disorder is a contested construct, so it is important to closely examine the origins of, and ideas held, about diagnosing mental disorder and how this has changed over time. This is of particular importance for this study because, without broad agreement about what constitutes mental disorder, legislation may be interpreted differently and, at times, applied without adequate justification. The differential application of law was clearly outlined in the introduction.

2.2.2 Diagnosis, labelling and discrimination

Campbell et al (2008, in Pilgrim and Rogers 2009 p949) commented that “stigma emanates from within the health services, particularly psychiatric diagnosis, which is never addressed in ‘anti-stigma’ campaigns” further noting that “there are no diagnostic tests with clear demonstrable results”. Increasing understanding of how mental disorder is framed as a concept may help understand whether, and if so how,

ideas around diagnosis, and associated stigma impact on those administering, or those affected by, the law. Markowitz (2013) argues that early notions about the impact of labelling in mental disorder remain relevant and suggests those lacking resources, who become subject to compulsion, can be particularly stigmatised. A brief look at the historical factors helps to explain why that might be.

In the context of discriminatory treatment of women in general, Ussher (1991) sought to understand labelling that takes place in psychiatry. Identifying witchcraft and menstruation as important, she notes that as early as the 16th century, some suggested that 'witches' may in fact be suffering 'delusions' and hallucinatory experiences and that rather than condemn them, they should be treated with compassion and treated by physicians. Szasz (cited in Ussher, 1991), identifies this as two sides of the same coin, men exerting unjustifiable control over women, initially due to witchcraft, and later in relation to 'madness'. Diagnoses based on medicalising women's sexuality and advocating cruel and inhumane treatment multiplied in the 1800s (Ussher 1991), for example 'hysteria' became a mainstay of diagnostic criteria for women throughout the 1800s and early 1900s and 'Clitoridectomy', was first practised as a cure for mental illness in 1866. Ussher (1991) asserts mental health law underpinned the systematic pathologising of women's sexuality over centuries. She argues that men are treated differently: men viewed as 'bad' and treated in the criminal justice system and women as 'mad' and treated within the psychiatric system. Rogers and Pilgrim (2001) concur, asserting that women with mental illness will be diagnosed with disorders characterised by self-harm where men, seen as criminally deviant, are more likely "within psychiatry

… to have labels which refer to and incorporate the threat of their behaviour" (Rogers and Pilgrim 2001 p202).

2.2.3 Causes and explanations for mental disorder

In the late 1800s, pioneers, such as Kraeplin and Blueler, began to categorise mental illness, identifying illnesses such as manic depression and schizophrenia (Johnstone 2008). From the mid-1800s, hereditary explanations for mental illness persisted until more scientific evidence relating to brain chemistry became available (Shorter 1997). Extreme approaches to treatment endured however, for example sixty-two thousand people with learning disabilities were forcibly sterilised in Sweden, until the practice was stopped in 1976. In the UK a segregation policy was instituted to prevent people with learning disabilities from having children (Williams 2006). Diagnosis can also be used to enforce 'norms' in society, for example, until 1973 homosexuality was defined, in various terms, as mental illness in the first three versions of the Diagnostic Statistical Manual of Mental Disorder (DSM) (Shorter 1997).

Rogers and Pilgrim (2001) examined the impact of differing perspectives on diagnosis by professionals and politicians and argued that 'predisposition' to conditions, such as schizophrenia, should be considered alongside social explanations. This, it is suggested, underpins the 'new' bio-psycho-social model favoured by community mental health services. However, Ghaemi (2009) points out that this model was first advanced by Grinker in the 1950s to promote biological, as opposed to psychoanalytic, aspects of psychiatry, revisited by Engel in 1980 to argue for the psycho-social perspective. The 'eclecticism' of this approach, which Rogers and Pilgrim (2001) see as desirable, is criticised heavily by Ghaemi (2009),

arguing that those using this model are free to interpret whichever aspect they choose (usually psychoanalytic, sometimes social) and that this can result in the imposition of dogma, based on the beliefs of the clinician. He argues for method-based psychiatry as advanced by Karl Jaspers or more humanist approaches as advanced by Osler.

Diagnostic manuals utilised by medical professionals, both DSM 5 (American Psychiatric Association 2013) used in the USA and Australasia, and The International Classification of Disease (ICD 10) (World Health Organisation 1992), used in Europe, are seen as controversial. This is due to reliance on groups of doctors debating and finally agreeing on the component 'symptoms' or observable behaviours which constitute a particular illness (Bracken et al 2012; Coppock and Dunn 2010), a process which Shorter (1997) described as diagnosis by committee. These diagnostic systems are based on medical perspectives, yet symptoms of mental illness often relate to individualised social interactions and behaviours, factors which do not readily lend themselves to being measured (Coppock and Dunn 2010; Johnstone 2008).

2.2.4 Terminology and trends in diagnosis

The impact of terminology associated with diagnosis was recognised when Section 328 of the 2003 Act updated the term 'mental handicap' from the 1984 Act to learning disability. Whilst it is acknowledged even this term is controversial, it is used throughout this study as it is the current legal terminology in Scotland. A Scottish user-led self-advocacy organisation, note on their website that they prefer the term learning difficulty (People First 2012). Williams (2006) highlights negative connotations associated with the word 'disability', suggesting 'difficulty' implies that

this can be more readily overcome. The language of diagnosis, in this case ‘learning disability’, can therefore lead to negative labelling.

The changing nature and understanding of conditions can impact on the use of legislation. For example, autism was identified, firstly as ‘infantile psychosis (which) was regarded as synonymous with childhood schizophrenia’ (Ghaziuddin 2005, p174), then as a sub-heading of schizophrenia, and only in the 1960s were the two conditions separated. Ghaziuddin (2005) argues that care must be taken not to overlook conditions such as depression, which are treatable with medication, in those with autism. The Mr N inquiry (MWC, 2012f), asserts that autism is the ‘poor relation’ in psychiatric services where specialist skills and knowledge are seen to be lacking, echoing Ghaziuddin’s (2005) concerns around poor care for this group. This inquiry also highlights failure to use the legislative framework appropriately because of perceptions about ‘treatability’. Personality disorder, previously excluded from interventions under mental health law, partly because of perceptions about treatability (Scottish Executive 2001c), was clearly included in the 2003 Act. The Mental Health Act 2007 (MHA 2007) failed to specify personality disorder separately in England and Wales, the implications of which are discussed in more detail in s2.10.3.

2.2.5 Disagreements between and within professional groups

Following the development of psychotherapy led by Freud and others, increasing numbers sought help for psychological disturbance through doctors’ surgeries (Shorter 1997). Gauchet and Swain (1999) express strong views about Freud’s work, suggesting that his failure to question assumptions contributes to totalitarian ideologies. Becker (1973) noted that homosexuality, crime, politics and art have all at

some point, in some places, been seen as mental illness. Furthermore he identified the increasing enthusiasm of psychiatrists to define as mental illness: “anything and everything in which they could detect any sign of malfunctioning, based on no matter what norm” (Becker 1973 p6).

2.2.5.1 The anti-psychiatry movement

Even from within psychiatry there were challenges about over-dependence on pharmaceutical solutions. R.D. Laing and the self-styled ‘anti-psychiatrists’, in the early 1960s, argued that madness was generated from within the family and that psychiatry merely tried to drug people into submission, rather than tackle the causes of illness. Laing established community houses in London where peer support and psychiatric input was offered rather than drugs (Shorter 1997). Following allegations of malpractice and poor results these were eventually closed down but the debate over treatment and diagnosis persists. A discussion paper published by the Maudsley, equates diagnosing schizophrenia to searching for meat in a hamburger: “Does the hamburger contain any meat or is it an artificial construct without any biological reality at its core” (Van Os and McKenna, 2003 p3). Tummey and Turner (2008) claim that when this was debated at a Maudsley discussion group in 2003 there was a tied vote as to the existence of schizophrenia, long after the anti-psychiatry movement was at its height. Van Os and McKenna (2003) nevertheless criticise the anti-psychiatrist stance, citing significant inconsistencies in rejecting rational or scientific approaches altogether and making unsubstantiated claims.

2.2.5.2 Postpsychiatry or critical psychiatry

Gauchet and Swain (1999) urge consideration of more transformational approaches, informed by our own history and ideas of French post-modernists, such as Foucault, who challenged the basic ideas around madness. Thomas and Bracken (2004)

examine the move from early positivist approaches, associated with modernism, to a post-modern perspective as expressed by Ingleby, Foucault and Heidegger. These perspectives question the notion that psychiatric diagnosis and treatment can be clearly defined, emphasising concerns about value-laden approaches and male domination as highlighted earlier. Failure to take account of social factors, alongside these concerns, has given rise to the Critical Psychiatry or postpsychiatry school of thought. This has been influenced by user-led movements, recovery principles and psychiatrists, who were uncomfortable with the emphasis on approaches to diagnosis, which excluded social factors (Bracken and Thomas 2001; Rogers and Pilgrim 2001). Wallcraft (1996) partly blamed these failures to consider social factors on hospital-focused approaches to treatment. The postpsychiatry standpoint argues that a more 'hermeneutic' approach, addressing the perspectives of service users and the social and cultural factors which impact on their lives, must be taken into account when considering psychiatric diagnosis and treatment (Thomas and Bracken 2004).

The postpsychiatry ethos, supported by a substantial number of practising psychiatrists (Rogers and Pilgrim 2001) is clearly far removed from a purist 'medical model' and better reflects the more holistic approaches advocated through the Scottish legislative framework. These perspectives assert that psychiatry remains an evolving and dynamic discipline. Other aspects of these changing approaches are returned to shortly when looking at the developing role of the psychiatrist and later when examining interdisciplinary working.

2.2.6 Diagnosis as an eligibility criterion

In the modern context, diagnosis of mental disorder is a gateway to intervention under the legislative framework in Scotland, yet the literature shows diagnosis lacks objectivity and is subject to change. Presence of mental disorder is core to the 2003 Act under s328, but interventions under the 2000 and 2007 Acts are also largely founded on the same diagnostic criteria. S1(6) of the 2000 Act makes clear that incapacity must relate to mental disorder, or communication difficulties, but the vast majority of causes for incapacity relate to mental disorder (MWC 2012a). Whilst the 2007 Act includes disability and frailty as possible criteria again, in practice, mental disorder is almost always a factor (MacKay et al 2011). Thus diagnosis of mental disorder is central to intervention across the legislative framework.

Consequent to the earlier noted changes under the 2000 Act, incapacity is no longer viewed as 'global', but is decision–specific. The possibility of other professionals 'diagnosing' incapacity is discussed extensively by commentators and included in guidance by policy makers (Maas-Lowit 2010; Scottish Government 2008a; Killeen 2008). However, the predominant legal responsibility for diagnosing capacity under the Act sits with medical professionals. This aspect of the 2000 Act will be discussed in more detail later in this review.

2.2.7 Concluding thoughts

As noted at the outset diagnosis of mental disorder underpins most interventions under this legal framework. Ideas about diagnosis have clearly fluctuated over centuries and doctors now use ICD10 or DSM V to bring objectivity to the process, though this remains controversial. Debates over approaches to diagnosis have been discussed, which provide some insight into why mental disorder has been

stigmatised and treated with suspicion for generations. I believe that lack of agreement about diagnosis and incapacity contributes to differential use of the legal framework in Scotland today, and that antipathy towards medical dominance may influence other professionals' attitudes to legal intervention. All these areas will be reflected upon in analysing the primary data. Campbell, Healy and Brophy (2006 p29) raise important ethical concerns in this regard: "if there are fundamental problems of definition about terms as anomalous as mental illness and risk then it becomes much more difficult to justify interventions which are so coercive".

2.3 'Medical' treatment responses

As diagnosis of mental illness is controversial, so too is treatment. This section examines the development of ideas around treatment in terms of medicines and wider social responses. Section 329 of the 2003 Act sets out the meaning of treatment in very broad terms, including: social and nursing care, drug treatments, psychological therapies and rehabilitation. One key purpose of all three Acts is to enforce treatment, but as with diagnosis, if there is disagreement about efficacy of particular approaches, there may be difficulties in interpretation of the law. This is likely to result in inconsistent usage and disagreement over what constitutes unreasonable non-compliance with treatment.

From a historical perspective part of the 'problem' in treating mental illness was lack of a secure evidence base (Shorter 1997), yet even now the same concerns arise. In a study, referred to in 2.3.2, Lewis and Lieberman (2008 p163) assert that "It is

perhaps not surprising that, in the context of a severe, chronic illness, clinicians are tempted to resort to untested measures".

2.3.1 Early drug treatments

Treatment in the early asylums was largely concerned with control and restriction, to prevent harm to the patients or others. These were mainly physical interventions in the absence of bespoke drug treatments; however, there was extensive experimentation, which resulted in significant harm to patients and in some cases death. Treatments included blood-letting, purging, cold baths, colonic irrigation, 'forced respiration' and administration of insulin to induce a hypoglycaemic coma (Coppock and Dunn 2010; Moncrieff 1999; Shorter 1997; Ussher 1991). Psycho-surgery was introduced in the 1940s, but high incidences of debilitating brain damage and death resulted in the imposition of strict controls (currently under ss234-236 of the 2003 Act in Scotland). Increased effectiveness of pharmaceuticals contributed to reductions in use of these approaches in the second half of the 20th century (Ussher 1991).

Use of Electro-Convulsive-Therapy (ECT), ingrained in popular psyche as punishment rather than treatment, by books such as *One Flew over the Cuckoo's Nest* (Kesey 1963), has endured despite its chequered history. ECT is now better regulated and is viewed as successful in treating entrenched conditions (RCP 2012; Rogers and Pilgrim 2001; Shorter 1997). Surveys undertaken by The Royal College of Psychiatrists (RCP) (2012) and Brindle (2012) show a significant reduction in use of this approach between 1999 and 2002. The RCP claim good success rates for treatment, citing clinical trials using 'false ECT', which demonstrate the efficacy of the approach. Conversely, Bracken et al (2012), from a postpsychiatry perspective,

cite research from the 1980s which suggest ‘false ECT’ was as effective as actual ECT and challenge assertions about its efficacy. Rodes et al (2003) also challenged RCP claims of 80% patient satisfaction, reporting that in a meta-analysis of studies, gathering patients’ views on ECT, a third reported significant memory loss.

In the absence of bespoke drugs, drugs for other conditions such as thyroxin, benzedrine, opiates and barbiturates were used to treat mental illness, which at best sedated patients and at worst had damaging side-effects (Moncrieff 2002). However, Lithium Carbonate, initially intended to treat cardiac patients, is still used to treat mood disorders, despite concerns about toxicity. Interestingly, Young and Hammond (2007) identified a radical reduction in use in the USA, linking this to drug companies promoting more expensive alternatives.

Ussher (1991) drew a parallel between historic non-interventionist treatments for hysteria, involving lengthy rest, isolation and absence of any mental activity, asserting that “current psychological treatment is equally prone to use torture and confinement, if in a different guise” (Ussher 1991 p75). Recent in-patient surveys in Scotland support this perspective, repeatedly referring to lack of activity, boredom and un-necessary confinement (Scottish Government 2009b). So, despite some successes the damage done by many of these treatments is clearly likely to remain a part of the folk history of mental illness and to reinforce negative ideas and stigma in relation to mental illness, in turn potentially leading to lack of confidence in the system and to poor compliance with treatment regimes.

2.3.2 Drugs specifically targeting mental illness

The first effective drug treatments for psychotic illness and depression emerged in the 1950s, specifically, the anti-psychotic drug, Chlorpromazine, and anti-depressants, initially Imipramine. Moncrieff (2002) explains how Chlorpromazine prescribing in French hospitals rose from 428kg in 1952 to 2,332,085kg in 1957. Although often credited with the mass exodus of patients from psychiatric hospitals, drugs were, and continue to be, only part of the recovery process (Coppock and Dunn 2010).

Anti-psychotic drugs, designed to treat psychotic illness, are also given to control behaviour associated with dementia, learning disability, autistic spectrum disorders and Huntington's Disease. Matthews and Weston (2003) examining the use of Thioridazine, an anti-psychotic drug widely prescribed in lower doses for 'challenging behaviour', report that 50% of people with learning disabilities experienced 'adverse events' when withdrawing from this drug. The UK Committee on Safety of Medicines in 2000 advised against routinely prescribing Thioridazine, due to the risk of irregular heart rhythms and sudden death (Matthews and Weston 2003). MIND (2001 in Coppock and Dunn 2010), expressed serious concerns, about the disproportionate, and at times inappropriate, use of such drugs to manage 'challenging' behaviours. So even drugs intended for use in specific mental illnesses are being used 'experimentally' for other conditions.

Clozapine was the first of a new generation of so-called 'atypical' antipsychotics and is widely seen as effective in patients who do not respond well to other drugs (Lewis and Lieberman 2008). However, users require frequent blood tests to ensure the

white blood cell count is not dropping, risking imminent death if the drug is not immediately stopped. Many question whether the high risks justify the treatment gains (Lewis and Lieberman 2008). Other atypical anti-psychotics generally present less Parkinsonian-like side effects, but Moncrieff (2002) suggests that objective evidence is lacking and that research into anti-depressants and anti-psychotics is partial at best. Lewis and Lieberman (2008) cite two large-scale, non-commercially sponsored, clinical trials in the USA comparing typical and atypical antipsychotics which found, with the exception of clozapine, that the newer drugs were neither more effective nor carried any fewer side effects, despite the drug companies' assertions to the contrary. They identify ongoing concerns about use of drugs intended for other purposes and crude use of anti-psychotic drugs, particularly prescribing two or more simultaneously without any evidence base, which they assert "doubles costs and multiplies safety risks" (Lewis and Lieberman 2008 p163). Rogers and Pilgrim (2001) list a range of concerns from patients relating to side-effects, breakthrough symptoms and frequent changes of drug regimes, further noting that even when accepting treatment, 66% of those with psychosis can expect relapse within two years.

Bracken et al (2012), from a postpsychiatry perspective, are scathing about overuse of antipsychotic drugs and minimisation of side effects, describing the relationship between drug companies and academic psychiatrists as a "shameful collusion" which damages "the profession's credibility" (Bracken et al 2012 p431). Kendall (2011, cited in Bracken et al 2012) described atypicals as a marketing ploy, which ignores risks associated with heart disease, leading to reduced life expectancy for people with serious mental illness.

The market for anti-depressants was even more competitive. Prozac (Fluoxetine) was the first of a wave of 'smart' anti-depressant drugs, Selective Serotonin Re-Uptake Inhibitors (SSRIs), introduced in the 1980s, targeting serotonin production in the brain. Describing this as part of a new phenomenon of 'cosmetic psychiatry', Kramer (1993) asserts this was said to promote happiness and fulfilment, not just treat depression. Shorter (1997) referred to such drugs as pharmaceutical accessories and a massive success for the drug companies. He reported that the weight loss associated with Prozac, unlike other anti-depressants, transformed the idea of insanity or madness into something more socially acceptable. Tummey and Turner (2008), assert that Prozac is just one more medicalised response to social and personal issues, reinforcing Ussher's (1991) assertion that psychiatry disproportionately treats mentally ill women with antidepressants. The postpsychiatry movement, in calling for greater focus on familial, social and economic roots of illness, also seeks to move away from such medicalised responses (Bracken et al 2012).

Given the wide-ranging concerns about modern psychiatric drug treatments refusing treatment may be a more rational response than is acknowledged by legislators. However, in the absence of any other successful treatments, such drug treatments are often an essential part of a treatment package. Advocates of postpsychiatry emphasise the need to ensure that drug treatment is proportionate, used in the context of wider social interventions and is openly discussed with patients (Pilgrim and Rogers 2009). This perspective is consistent with the underlying principles of the

Scottish legislative framework, particularly in respect of user involvement and having a range of options.

2.4 Psycho-social interventions

According to Shorter (1997) debate raged between psychologists and psychiatrists over the relative merits of psychological therapies and drug treatments. Rogers and Pilgrim (2001) question the evidence base for efficacy of psychological therapies, though acknowledge potential for damage to physical health is avoided. Bracken et al (2012) argue strongly for wider consideration of alternative approaches, particularly regarding recovery-based approaches, a clear policy direction in Scotland. One of seven central themes in The Mental Health Strategy identifies recovery as “a key aspect of an integrated approach to improvement work in mental health” (Scottish Government 2012d p51). Similarly, Commitment 4 of the Delivering for Mental Health Plan pledges to “increase availability of evidence-based psychological therapies for all age groups” (Scottish Executive 2006a p4). A combination of psychological and pharmacological approaches is viewed as beneficial for major mental illness, but in anxiety-related or less severe depressive conditions, psychological interventions or lifestyle changes are deemed more effective (Scottish Executive 2006a).

There is little doubt that approaches which engage with the lived experience of service users are potentially of great value, however, the quality of services which purport to offer such interventions is questionable. A recent King’s Fund briefing paper (Gilburt 2015) sounded a note of caution about the motivation and evidence

for alternative approaches. Gilburt asserts that mental health services in England and Wales experienced financial cuts of 40% in the previous two years. Consequently, she suggests they have diverted treatment to recovery and outcome focussed projects, without a sound evidence base, for the express purpose of reducing costs. She further asserts that this led to reduced access to qualified professional staff for those with severe mental illness, that only 14% of patients were said to be satisfied with the outcomes of acute inpatient treatment and that increasing numbers were dissatisfied with community-based treatment. This suggests that untested approaches may also be a feature of non-medical psychiatric treatments.

Discussion about psychological therapies is limited in this thesis, however, as the focus is on the Scottish legislative framework. Whilst a range of options, including psychological therapies, are promoted through the principles of each of the Acts, coercion under the 2000 and 2003 Acts usually relates to residence, access for professionals or administration of medication. As Campbell et al (2006) note, social interventions or psychological therapies for the most part cannot be imposed on the unwilling or unmotivated.

2.4.1 Care arrangements: the growth of institutional care

Because coercion often relates to residence, this element of medical treatment merits detailed consideration. Section 329 of the 2003 Act makes clear, that medical treatment for those with mental disorder includes care arrangements. The 2007 and 2000 Acts enforce and encourage care and protection for a wider group namely those with disability, where mental disorder or incapacity is a factor. Historically many people with physical disabilities have been diagnosed as having mental

disorder and are treated accordingly, for example those with hearing impairment had often been treated as mentally handicapped (Brown 2006). There are difficult and complex issues around providing for the care and varied accommodation needs of this diverse group of people. As with treatment and diagnosis, a historical context helps to contextualise the current debates.

In 1377 The Bethlem Royal Hospital in London was the first lunatic asylum in the UK, yet by 1826 only around 5000 people were detained in the UK in such institutions (Shorter 1997). These establishments were mostly private businesses overseen by non-medically qualified superintendents providing for basic care needs rather than therapy. Until the mid-18th century in the UK the mentally disordered were confined at home, in poor houses, prisons, workhouses, private 'madhouses' or in the few state-provided institutions. Private establishments catered for those who were able to pay and those who could not were frequently locked up, or even chained up, in attics, sheds and barns (Coppock and Dunn 2010). Conditions in pre-19th Century institutions and for those living in the community were seen as very poor and patients were treated like animals and subject to public ridicule (Shorter 1997; Scull 1996; Ussher 1991). Fear by association developed, whereby relatives of the mentally disordered wished to 'hide' their relative from public view (Coppock and Dunn 2010). Many examples exist in the UK and elsewhere of people, mainly women, arbitrarily detained in institutions by parents or spouses because of their apparently inappropriate social behaviour, pregnancy or promiscuity. In 1860 Elizabeth Packard, was detained for three years in an Illinois 'insane asylum', based on her husband's declaration that she was insane for openly disagreeing with his religious views. She wrote several books, including 'Modern Persecutions or Insane

Asylums Unveiled' (1865) describing the degradation she and fellow patients experienced. She successfully appealed against her detention and along with others, campaigned for the rights of women and of the mentally ill.

Scull (1996) outlines developments in the asylum movement in the UK. He identifies a shift from early therapeutic environments to "well-tended cemeteries for the breathing" (Scull 1996 p7). Scull (1996) notes that even well-intentioned institutions slipped into more repressive regimes. However, he acknowledged that patients did achieve some benefit in the more humane institutions such as the York Retreat, where kindness and compassion replaced the harsh control elements of other institutional approaches. Coppock and Dunn (2010) made similar observations about this institution, but noted that this improvement followed the suspicious death of a patient in 1791, perhaps anticipating modern trends of change following adverse incidents (Reith 1998). In France about this time the psychiatrist Pinel adopted a less restrictive environment for patients, introducing a more caring approach within asylums (Shorter 1997; Coppock and Dunn 2010). The first public asylum in Scotland was opened in Montrose in 1781 for pauper and private patients (University of Dundee n.d.).

Unfortunately, this more positive approach was lost as throughout the late 1800s ever larger institutions were developed to deal, not only with the mentally ill, but with older people and those with learning and physical disabilities. Coppock and Dunn (2010), citing Porter (1987) and Torrey (2003), noted that demand followed on from supply and institutions were filled as soon as they were built. There was a huge increase in the numbers of the 'insane', reflecting the earlier noted imprecise nature

of diagnosis (Coppock and Dunn 2010; Johnstone 2008). Scull (1996) graphically described a growing band of ‘chronic’ patients who remained in the institutions, partly because the promised ‘cure’ could not be realised, but also reflecting a changing societal attitude to these long-term patients, which labelled them as feckless and undeserving. Scull (1996) cited figures from the late 1800s demonstrating systematic cuts in dietary intake of patients, to the point of almost starving female patients, which he claimed was only addressed in 1918 when it became known that one third of the UK asylum population died in the previous 12 months.

New legislation, reports by various committees and commissions and the establishment of regulatory bodies led to significant improvements in care and treatment in hospitals, according to Rogers and Pilgrim (2010). However, they note that despite public psychiatric hospitals being brought under the control of the newly created NHS in 1948, Victorian-built institutions of the time continued business as usual. Scull (1996) discussed the increasingly negative overtones surrounding the concept of asylum, quoting Erving Goffman extensively. Goffman (1968) writing about his experience and understanding of psychiatric institutions, as a participant observer in a Washington psychiatric hospital, identified institutionalised behaviours that the regime generated. Critics of Goffman’s writing, point to his failure to employ rigorous methodological controls and that he incorporated his own preconceptions about asylums into his writing, for example, expansive generalisations likening asylums to concentration camps (Weinstein 1982, Scull 1996). Weinstein (1982) cites many researchers from the 1970s and 1980s who refute aspects of Goffman’s work, around the self-image of patients and his views on the ‘total institution’, though acknowledges these are widely accepted concepts.

Nevertheless, Goffman (1968) raised important issues about institutional care, which continue to influence thinking around such provision (Weinstein 1982; Scull 1996). In particular, his ideas around the stigma attached to individuals subject to institutional care and the behaviours adopted by patients within institutions continue to have resonance in the present day. Foster and Roberts (1999) examined the impact of containment on people with severe and enduring mental illness and their carers, whether in institutions or in the community. They suggest the difficult nature of this work results in compartmentalisation, whereby staff separated themselves psychologically from their patients, inevitably depersonalising the relationship and leading to poor outcomes for the 'cared for'. Two dominant approaches are described: 'warehousing', which simply meets service users' dependency needs, and 'horticultural' approaches which seek to empower and promote independence, but minimise important dependency needs, such as help with basic tasks of day-to-day living. Foster and Roberts (1999) argue that a holistic approach requires a combination of the two and that a new less defensive approach, based on individual need rather than perceived trends in care provision, is needed. They suggest that in the modern context, for some, life in the community is worse than in the large institutions.

Scull (1996) contrasted the view of those who created the asylums, that any asylum, no matter how bad, was better than being open to exploitation and degradation in the community, with the views of sociologists and modern thinkers, at the other extreme, that any community-based placement will be better than in-patient treatment. He described both perspectives as equally foolish: "it is difficult to decide which delusion

has proved the more harmful to the seriously handicapped and chronically disabled who once thronged the back wards of these institutions" (Scull 1996 p13). Campbell et al (2006) also identified potential problems with these rigid beliefs about community care, when discussing use of compulsion across several international jurisdictions. The Scottish Government (2012f) reported that since 'the same as you' policy was launched in 2000 (Scottish Executive 2000a), 11 of the 19 long-stay hospitals for learning disability had closed and of the 7000 beds identified in the original report only 318 remain. The reason some beds remain open is attributed to lack of housing and appropriate care packages. In the final recommendations the statement that "no-one's home is a hospital" (Scottish Government 2012f p61) suggests the continuing presence of the above noted rigidity of thought (Scull 1996; Campbell et al 2006).

In the same way that public horror at the treatment of people in the community led to the creation of asylums, similar horror at treatment within asylums, emerged in the 1970s. Several major inquiries pointed to abuse in psychiatric and 'mental handicap' hospitals, further fuelling the drive to community care (Rogers and Pilgrim 2001; Shorter 1997). Beardshaw's (1981) analysis of twenty-four significant inquiries in English and Welsh hospitals examined the deaths of patients, by suicide or neglect. These inquiries identified poor living conditions and financial, sexual and physical abuse as contributory factors. Many inquiries focussed on the failure to act on expressed concerns, an issue which continues to have resonance.

So, to summarise, early community-based responses to mental disorder were gradually replaced by institutional care in various formats. The original concerns over

poor treatment of the mentally disordered in the community were replaced by similar concerns about the treatment of people in institutions. Since the mid-1950s the emphasis has moved back from institutional to community care and a wide suite of legislation and policy has been put in place to reinforce this changing dynamic. The following section takes a closer look at the development of community options and related law and policy.

2.4.2 Care arrangements: De-institutionalisation and community care

Noting that UK asylum numbers peaked in 1955 at 150,000, Coppock and Dunn (2010) identified four major factors that contributed to a reduction to 50,000 by 1992. These were the development of new and effective drugs, wide-ranging criticisms levelled at institutions as outlined earlier, economic imperatives and therapeutic optimism. This last factor related to innovative psychiatrists, creating therapeutic communities and introducing psychotherapeutic approaches into treatment regimes. Scull (1996) cited economics and the push towards marketisation, encouraged by the NHS and Community Care Act 1990, as significant drivers to the reduction in the number of beds. However, Rogers and Pilgrim (2001) sound a cautionary note about Scull's analysis, arguing that the move to deinstitutionalisation was rooted in more complex attitude changes at government level and emerging, effective, drug treatments. However, they agreed that economic ideology has played a significant part in the widespread closure of hospitals since the 1970s.

The role of economics has played a significant part in deinstitutionalisation and in poor standards of care in many ways. Scull (1996) asserted that dependency on services was viewed as somehow immoral, particularly in respect of people with chronic mental or physical health problems, those living in abject poverty, or who

originated from minority ethnic groups. He suggested services were subject to frequent cutbacks and that there is little sympathy amongst the privileged for those "who must feed from the public trough" (Scull 1996 p14). Policy on learning disability and mental illness (Scottish Government 2013b) promotes independence and recovery approaches, but risks falling into the same trap, namely that dependency on services is unacceptable and may be used as an excuse to cut services (Gilburt 2015).

Although numbers in psychiatric hospitals have been significantly reduced and care homes and hospitals have become subject to strict regulatory regimes, underpinned in Scotland by the Regulation of Care Act 2001, widespread neglect across the health and care sector still appears to be a problem, albeit less obvious. The Mid-Staffordshire inquiry (Francis 2013) identified many avoidable deaths amongst hospital patients, arising from lack of basic care, including access to food and drink. Heaven et al (2013) cite evidence that 60% of older people in hospital are either malnourished or at risk of malnutrition whilst in hospital. Stow et al (2015) examined nutritional management arrangements in care homes and cited figures of between 30 and 42% of residents being at risk of malnutrition, a particular concern for those with advanced dementia and severe mobility problems. Moore's research (2017) identifies no improvements in the incidence of abuse in care homes, since the inception of the Care Quality Commission (CQC) in 1984. He cites statistics produced by the CQC in 2016: "26 per cent of residential care homes and 41 per cent of nursing homes (in England and Wales) have been rated…as either 'inadequate' or as 'requires improvement', that is, they do not meet all of the required 'essential' or 'fundamental' standards (CQC 2016a, pp58-59, cited in Moore 2017

p419). The weakness of the regulatory role of the CQC was starkly highlighted when a TV documentary identified serious concerns about Winterbourne View, a small learning disability in-patient unit (Cole 2011). Despite many previously reported concerns from staff and relatives, it was only after the documentary was broadcast, that a CQC investigation identified a ‘catalogue of failings’ in the unit.

Concerns about community care in Britain are profound as noted above, but similarly so in the USA and Canada. Knowles (2000) documents the experience of people in Montreal, but generalises to comment on the direction of community care in G7 countries. She notes that responsibility for day-to-day care and treatment for people with mental illness, living outwith psychiatric institutions, has been handed back, from the state to municipalities and religious and philanthropic groups. Knowles (1999) describes some ground-breaking community care initiatives across the USA but notes that resources have not accompanied the rapid decarceration of people to enable community services to meet the needs of most of those affected. Acknowledging that localisation of services should underpin the widely supported personalisation agenda, she challenges the notion that communities have capacity to support people with chronic and enduring mental health problems, where family relations have often been significantly, if not permanently, fractured.

The structure of health and social care services in the UK is different but there is constant tension about budget and spending priorities (HM Treasury, 2010). Campbell et al (2006), cite evidence that inadequately resourced community orders do not work, especially in rural areas where resources are less available. In a later paper Campbell and Davidson (2009) argue that use of coercion is difficult to justify

ethically, where resources are limited. However, as Knowles (2000 p7) put it, it is not just about money, it is “a broader social problem concerning the terms on which the mad and the rest of society co-exist. It is about what happens when the aliens are let out of the asylum and there is nowhere special to go”.

In the 1980s the Conservative government seeking to reform community care and roll back state intervention, commissioned the Griffiths Report (Griffiths 1988), paving the way for the NHS and Community Care Act 1990 (the 1990 Act). This introduced wide-ranging reform of the relationship between social work agencies and the private and voluntary sectors resulting, not only in major changes for social work practice, but increased impetus for hospital closures (Rogers and Pilgrim, 2001). The care manager role was created and the private and voluntary sector had an increasing role in service provision. Across the UK older people were gradually moved from long-term hospital beds into care homes. Hospitals for mental disorder, specialist hospital-based facilities for hearing and sight impaired and those with chronic physical illnesses were either closed or the provision substantially reduced (Peace 2003). As these specialist facilities have closed the need for more targeted services has increased. For example, Walker, Walker and Ryan (1996) present evidence about the so-called double-jeopardy of old age and learning disability, whereby the life expectancy of people with learning disability almost matches that of the general population. Resettlement from long-stay hospitals and community care options, known to impact on older people in a sometimes negative way in terms of social isolation and lack of meaningful activity, reportedly had an even more profound, detrimental, effect where learning disabilities co-exist. Walker, Walker and Ryan (1996) commented on earlier research, which reviewed 102 patients with

learning disability (Walker et al 1993 [in Walker, Walker and Ryan 1996]), forty per cent of whom were over fifty, discharged from long-stay hospital in England during the early 1990s as part of a resettlement strategy. It was found that whilst learning disability services for adults are geared towards more inclusive and empowering approaches, old age services are less innovative and are ill-prepared to meet the needs of those with learning disability. Walker, Walker and Ryan (1996) note that even in learning disability services there have been difficulties gaining acceptance for normalisation principles, known as O'Brien's (1986) 'five accomplishments' of choice, respect, community living, competence and participation. Resettlement was more often to large scale units than supported accommodation. Recent Scottish Government papers planning health care and services for older people promote normalisation principles (Scottish Government 2007a; Scottish Government 2007b), but, nevertheless, it seems this study's findings still have resonance, as these principles are not translated into practice. The philosophy underpinning Government policy seeks to keep older people in their own homes as long as possible, but when a move is required, it is likely to be to a large-scale care home as described by Walker, Walker and Ryan (1996). Lynch (2014) highlights an increasing trend towards larger residential units, asserting that outcomes for those in units of more than 50 beds are likely to be poorer.

There have been two distinct shifts in the provision of community care since the 1990 Act was introduced. For many groups this involved moving from hospital and large scale institutional care, to smaller 'group-care' facilities, which combined small-scale residential care and heavily supported independent living or where possible, people returned to or obtained their own tenancies (Gilburt and Peck 2014).

Changes in housing benefit law and associated regulations (Housing (Scotland) Act 2001), led to more individualised housing support in Scotland, resulting in the second significant change, whereby the current trend is for people with disabilities to have their own tenancy. Peripatetic support is accessed largely through social work and voluntary services. Many are concerned that for people with significant disabilities, there is an increased risk of social isolation and exploitation. Williams (2006) discusses some of the environmental impact of placing people with learning disability in individual tenancies, including potential isolation from friends and families. Brown (2006) asserts that the combined expertise in caring for vulnerable groups in larger scale institutions is now diluted and care is often passed to “carers with little training and experience” and where “low morale and sense of personal worth” seems to be increasing (Brown 2006 p43). He refers here to older people but similar issues are likely to affect others receiving such support.

So-called ‘very sheltered’ or ‘extra care’ housing projects, provide the level of care that Walker, Walker and Ryan (1996) advocate, but these are expensive (Baumker, Netton and Darton 2010; Petch 2014) and the evidence base for successful outcomes remains unclear (Kneale and Smith 2013). This type of accommodation is intended to provide a home for life, by providing 24-hour support, meals and focused activities to people living in their own tenancies. Many of those who move in initially have few support needs, yet Petch (2014) estimates average costs at around £416 a week, a potentially prohibitive figure for those who are self-funding. There are also questions over how well these facilities can deal with dementia and so-called ‘challenging’ behaviours (Kneale and Smith 2014).

Care in domestic settings then is fast becoming the norm for people with long-term needs as hospital provision shrinks. A new relationship has developed, between those previously incarcerated in asylums and their communities, creating wide-ranging challenges for communities and for service providers. These include how to ensure user involvement, respect dignity, manage risk and avoid stigma. Wallcraft (1996 p181) perhaps anticipating this approach characterised it thus “The policy of community care means that dialogue between sanity and madness is re-opening and the ‘mad’ this time have a seat in the debating chamber”. Wallcraft (1996) goes on to raise an important question, as to whether we are simply transferring an asylum-based medical model into the community, with its reliance on drugs, ECT and restriction of liberty, without looking at how this might be done differently. She also, importantly, questions whether access to asylum will be available for those who need it. These same points are identified by Bracken and Thomas (2001) in relation to the hospital focus of community treatment and by Pilgrim and Rogers (2009) with regard to limited access to hospital for those who present acute risks. Pilgrim and Rogers (2009) assert that with widespread closure of psychiatric hospitals, the criteria for admission focus on risk as well as diagnosis, and that in fact most admissions involve coercion. They argue that this creates a high risk environment with little actual therapeutic benefit. Bracken and Thomas (2001) argue that whilst psychiatrists should have a role in diagnosing, decisions about compulsion should be taken by others, such as social workers, who can bring wider perspectives in relation to cultural and social factors. It is further suggested that decision-making ability should be a core criterion for compulsion, otherwise coercion may be used to prevent people from making legitimate lifestyle choices. Of course decision-making ability is now a core criterion for civil compulsion under the 2003 Act.

The Scottish Government has signalled its intention to actively promote personalisation principles, giving people greater control over their own care, providing personalised budgets and allowing for greater choice through the Social Care (Self-directed Support) (Scotland) Act 2013 (SDS 2013). However, this is against the backdrop of ever-decreasing local authority budgets. The Coalition's 2010 Spending Review was contradictory, on the one hand stating that priority will be given to: "removing ring-fencing around resources to local authorities and extending the use of personal budgets for service users" but on the other provide "a settlement…[which] radically increases local authorities' freedom to manage their budgets, but will require tough choices on how services are delivered within reduced allocations" (H.M.Treasury 2010, p8). The Coalition of Care and Support Providers (2012) note that cutbacks of between four and twenty per cent were occurring across local authorities in Scotland. The Convention of Scottish Local Authorities (CoSLA) opposed proposed budget cuts for local authorities in Scotland in 2016/17 amounting to £350 million, or 3.5% on average, however, the sanctions threatened by the Scottish Government for non-compliance, as predicted by CoSLA, drove councils to accept these in full.

The provision of accommodation, care and support have particular relevance for the current study, since as noted at the beginning of this section, the main areas which can be enforced under the legal framework relate to residence (hospital or care home) and medication. Compulsion under these Acts is based on assessment by apparently qualified professionals, subject to associated legal checks and balances. However, if the quality of these options cannot be guaranteed then the underpinning

justification for use of compulsion may be in doubt. Whether the outcomes for this push for community care can provide demonstrable ‘benefit’, a key principle of all three Acts, will be an important measure of this justification. The next section looks more closely at this in the context of enforced treatment and associated processes.

2.5 Decision-making and enforced treatment

The discussion about drug treatment has demonstrated that despite advances in pharmaceutical treatment and community care there are considerable, well-researched, concerns about the efficacy and potential harm of drugs used in psychiatry, and about the justification for coercion in the management of risk. From the literature reviewed above in relation to care arrangements it seems that increased emphasis on community treatment and community living has consequences for protecting adults at risk of harm, for equitable provision of care and treatment, and promotion of welfare. Abuse within the system, supposedly now addressed by regulators, remains problematic (Cole 2011; Moore 2017). Enduring memories and accounts of experimental treatments, pharmaceutical or otherwise, remain prominent in the human psyche and according to many writers are one of the principal causes of stigma and fear around mental illness. Bracken and Thomas (2001) discuss this suspicion around treatment, in the context of coercion, and assert that psychiatry needs to acknowledge that “patients and the public know that a diagnosis of diabetes unlike one of schizophrenia cannot result in their being forcibly admitted to hospital” (Bracken and Thomas 2001 p725) Scull (1996), making a more general point in relation to treatment, draws similar conclusions, that society fails to understand why patients with long-term mental disorders do not co-operate with

treatment as fully as might someone with a physical illness. Indeed, many individuals subject to mental health law find themselves labelled as ‘non-compliant’ with medication or in some other way ‘uncooperative’, some of whom, may have legitimate objections to treatment. Wexler (2000) posited that this non-compliance may arise from poor communication from doctor to patient, about what was required and why.

Referring back to the initial reason for examining aspects of treatment, it is emphasised that the underlying assumptions, and indeed legal principles, for intervening on a compulsory basis under the Scottish legal framework are predicated on potential benefit. If treatment-focused interventions are not based on sound evidence, then enforced treatment under the 2003 Act may be less justifiable. Key criteria for use of compulsion related to availability of effective treatment (s57 (3)(b)(ii) the 2003 Act) and impaired decision-making ability (s57(3)(d) the 2003 Act), are underpinned by assumptions that refusal to comply is not rational, but illness driven. Wexler (2000) further suggested that there is an unspoken assumption in mental health law that those discharging legal functions are appropriately qualified to judge which interventions are suitable. As will become clear in later discussion, the 2003 Act does try to address many potentially problematic issues, through principles enshrined in the Act and specific sections such as ss25-31, which demand adequate provision of good quality care. Bearing in mind earlier comments around recovery-focused approaches, several principles of all three Acts, as well as general guidance in the codes of practice, encourage professionals to take account of the views of service users and informal carers. Despite the range of measures which seek to broaden the focus of the legislative framework to take account of social factors, the

balance of power remains with medical professionals. No action can take place under Parts 3 to 6 of the 2000 Act without a medical practitioner confirming incapacity and psychiatrists lead most interventions under the 2003 Act based on medical diagnosis. With the support of MHOs, psychiatrists impose detention and seek authorisation from Mental Health Tribunals in Scotland for longer term compulsion. These decision-making tribunals consist of a psychiatrist, a general member and a lawyer, who chairs the proceedings. Though users and carers are represented amongst general members (MHTS 2013), the percentage is not in the public domain and the remaining members are professionals with an interest in mental disorder. Only the 2007 Act allows intervention without medical support, though as noted earlier it relies on the same definition of mental disorder and most interventions relate to people with a diagnosis of mental disorder (Ekosgen 2013).

Whilst this legislative framework is innovative and does take account of important issues highlighted in this discussion around treatment and diagnosis, there is little research that attempts to establish how far the framework succeeds in involving service users and carers or achieving beneficial outcomes. This study seeks the views of those discharging local authority functions, in relation to the legislative framework and its stated objectives. The overall utility of the legislative framework from the perspective of researchers and commentators will be examined later in this Chapter. The next section however, looks in more detail at how medical professionals have come to take on such a dominant role in the process.

2.6 The role of psychiatry

Medical professionals, particularly psychiatrists, have a pivotal and specific role in interventions under the Scottish legislative framework. Since the 1960 Act, the MHO has also had a specific, independent role, in detention, compulsion and incapacity. The 2000 and 2007 Acts additionally introduced legal duties for other local authority staff. Understanding how psychiatry has developed within the field of medicine helps explain why this independent social work role was necessary and sheds light on the complexities of interagency working, integral to these Acts. Relationships between social workers and psychiatrists may have some bearing on differential use of the legal framework and practitioners' perspectives as to its usefulness. As already suggested in relation to diagnosis and treatment, historic factors about these roles may have a strong influence on present perceptions.

By the mid-1800s, the medical profession laid strong claim to managing the mentally ill and defined mental illness as a disease (Coppock and Dunn 2010). In the late 1800s and early 1900s psychiatry emerged as a specific medical discipline and other professions, such as psychologists and social workers, gradually became involved (Shorter 1997). The reasons that power and control in the mental health system fell to psychiatrists as opposed to other professionals are complex. Administration of asylums in Scotland until the mid-1800s was undertaken by Boards largely made up of businessmen and artisans, leaving medical practitioners with limited responsibilities (Houston 2001). Medical practice with the insane was seen by other medical practitioners as having very low status compared to other branches of medicine (Houston 2001; Shorter 1997). Houston (2001) examines decision-making systems concerning mental incapacity and treatment in the 18th century in Scotland.

He reports that between 1701 and 1818, juries (of whom only 2.5% were medically qualified) approved decisions in civil courts, presided over by Sheriffs. Court processes often involved sorting through evidence and hearsay to come to some reasoned decision, partly about treatment, but often about managing financial circumstances. Consequently lawyers became the dominant profession, whilst doctors were more likely to be witnesses. Arguably little has changed in that sheriffs adjudicate on guardianship applications (the 2000 Act) and tribunals, chaired by lawyers, decide on compulsion under the 2003 Act, all based on evidence from medical and social work 'witnesses'. The move away from legal dominance, from the early 19th century, was an attempt to avoid hearsay evidence and introduce more objective assessment of a patient's mental state. Interestingly Pilgrim and Rogers (2009) identified tension between legal and medical authorities, during consultation processes for each significant piece of mental health legislation in England and Wales since the 1930s.

Shorter (1997) discusses the changing trends between institution and community and the market economics of psychiatry and suggests that business interests of psychiatrists, previously visible in the growth of large institutions, now stood in the way of more creative, individualised approaches. In the early 1900s ideas about activity and occupation started to turn these large institutions into more outward looking places (Rogers and Pilgrim 2001). Market economics pushed the boundaries of treatment and encouraged the newly developing profession of psychiatry to consider different directions: particularly the development of spa-based treatments. These to an extent replaced asylums, invariably for those with financial means, but also attracted a new client group, previously unknown to psychiatry (Shorter 1997).

The earlier noted ‘biological’ versus ‘psychological’ debate marked a significant division in the developing roles of psychiatry and psychoanalysis. Shorter (1997) noted that though psychotherapy had started in Germany, it achieved greatest prominence in the USA and endured as the strongest force in psychiatry until the mid-70s, when most USA university psychiatry departments were headed by psychoanalysis-focused practitioners. As psychiatrists can prescribe medication and provide psychotherapy, this uniquely distinguishes them from psychologists, medical and social work professionals. The widening of diagnoses was associated with growing claims for the efficacy of medication and positivist approaches helped to keep psychiatrists at the centre of detention and forcible treatment processes. (Thomas and Bracken 2004; Bracken and Thomas 2001)

Echoing Wallcraft’s (1996) concerns about transferring asylum processes into community care, Rogers and Pilgrim (2001) note that despite developments in treatments and more creative thinking within psychiatry, psychiatrists and other health professionals are socialised, educated and predominantly work within hospital settings. Furthermore, they argue that psychiatrists’ emphasis on medication and control was reinforced by dealing with fairly short-term acute admissions. A critical commentary on decision-making on compulsion by Approved Social Workers (ASWs) in Northern Ireland, demonstrated that the majority of assessments took place in hospitals, not community settings (Campbell and Davidson 2009). In Scotland, driven by policy makers, this is gradually changing with the closure of hospitals and introduction of community mental health services promoting more

community focussed responses (Scottish Executive 2000; Scottish Executive Health Department 1997).

A combination of medically-focused treatments and a lengthy history of dealing with the most severe forms of mental disorder have placed psychiatrists at the pinnacle of mental health professionals. Coppock and Dunn (2010) examine attempts to challenge the power of the psychiatric establishment, citing the anti-psychiatry movement, user-led involvement, community care legislation and the introduction of direct payments. All of these it is argued, attempted to rebalance the power between doctor and patient (as well as service provider and service user). However, this new found "consumerism has done very little to challenge the persistence of professional (and especially medical) hegemony in the mental health system" (Coppock and Dunn 2010, p124). Coppock and Dunn however, do not refer to the role of social workers in challenging this hegemony, again highlighting a gap in the existing literature.

Advocates of critical or postpsychiatry approaches seek to distance themselves from 'anti-psychiatry' perspectives and assert that they do not wish "to replace the medical techniques of psychiatry" (Bracken 2001 p727), but nevertheless question the dominance of psychiatrists in the system (Bracken et al 2012; Bracken 2001; Coppock and Dunn 2001). In relation to diagnosis and treatment, postpsychiatry principles set out a clear critique of the failures of psychiatry to take account of wider social factors and developing ideas around recovery, empowerment and enablement. It is interesting that Pilgrim and Rogers (2009) see this rather differently, arguing that medical dominance in mental health services "has been

undermined by the weakening of coercive powers about detention and treatment“ and by “disdain … from disaffected service users” (Pilgrim and Rogers 2009 p957). Evidence for this claim is based on changes in England and Wales, under the Mental Health Act 2007, whereby responsible medical officers become responsible clinicians, nurses undertake prescribing and oversee management of patients in the community, all of which dilute the psychiatrist’s role. None of this is reflected in the Scottish system where medical professionals remain firmly at the centre in terms of diagnostic and admission processes.

The role of the psychiatrist is of particular relevance to this study, in that the legislative framework as noted at the outset, places a considerable range of duties on the local authority, yet the real statutory power remains predominantly with the psychiatrist. These perspectives on the influence of psychiatry and medical practitioners will be considered when examining the legislation in more detail in this review of literature and when analysing the primary data. Perceptions about the historic role of psychiatrists in the treatment of mental illness and disability may contribute to understanding the roots of discrimination and stigma and reluctance to engage with the psychiatric system in the context of this research (Bracken and Thomas 2001).

In the context of examining the Scottish legal framework it is worth noting that other medical professionals, including GPs, forensic medical examiners and hospital doctors, also have decision-making power. For example, Power of Attorney (2000 Act), medical assessments under the 2007 Act and reports relating to compulsory treatment orders under the 2003 Act can all be authorised by registered medical

practitioners. Thus, even supposing the postpsychiatry movement can make in-roads into broadening the perspective of psychiatrists, this other group of professionals is likely to be less well-informed in relation to social factors and recovery principles.

2.7 The role of the social worker

Whilst it is important to understand the relationship between psychiatry and the legislative framework, for this thesis it is clearly necessary to understand how the social work role in mental health has developed. The psychiatrist has a central role in procedures under mental health and incapacity legislation, but likewise social workers and others discharging local authority functions.

Expertise developed within the Tavistock clinic to help shell-shocked war veterans promoted wider social work involvement in mental health from the early 1930s (Coppock and Dunn 2010). The social work role was viewed as therapeutic and focused on former patients, family work with in-patients' relatives or working in child guidance clinics. Social workers often worked alongside psychologists and psychotherapists to undertake these roles, indirectly challenging the dominance of psychiatry (Shorter 1997). The 1957 Royal Commission on mental health law recommended that the social work role should be firmly located in family work and resettlement in relation to mental disorder and subsequent mental health legislation in the UK began to make this a reality (Coppock and Dunn 2010). In Scotland the 1960 Act introduced appeal procedures, created the MWC and established the MHO role giving social work responsibilities in the application of law and provision of community-based services. However, it appeared that the Royal Commission's

intentions had not been achieved when the 1968 Seebohm report stated that “the widespread belief that we have community care of the mentally disordered is, for many parts of the country, still a sad illusion (likewise) social workers should be concerned with the whole family, learning how to make a family diagnosis, and be able to take wide responsibility and mobilise a wide range of services” (Seebohm Report para 353 and 339, in Coppock and Dunn 2010). Despite legislative reform across the UK, as noted earlier the prospect of a social work role in diagnosis, whether for mental disorder or incapacity, remains distant.

Across the UK, the adult social worker’s role has been gradually eroded, culminating in the 1990 Act where “the state monopoly of provision was replaced by a welfare market” (Brown 2006 p29) and care management has become the norm across all adult care groups. However, as the generic social work role changed, and arguably moved closer to nursing and occupational therapist roles, the social work role in mental health legislation was enhanced. The MHO role was further enhanced under the 1984 and 2003 Acts, role (similar to the ASW role elsewhere in the UK) in terms of making applications for compulsory admissions, consenting to detention and applying for guardianship. Rogers and Pilgrim (2001) explore the development of community and hospital-based care and the rights of people with mental disorder in these new developments, but surprisingly made little comment about the independent role that ASWs (and by implication MHOs) bring to decision-making. When comparing the roles of Community Psychiatric Nurses (CPNs) and social workers, conflicts are attributed to professional rivalry rather than to challenges arising from social workers’ independent, though one study cited suggests social workers are much more pro-active in accessing community resources (Rogers and

Pilgrim 2001). This failure to acknowledge the importance of the independence of the MHO or ASW seems to be an omission in this otherwise comprehensive account of the developments in the UK psychiatric system.

Campbell and Davidson (2012, 2009) highlight practice dilemmas social workers face, in balancing the duty of care and empowering aspirations of social work, against more controlling and coercive aspects associated with duties under mental health legislation. Use of coercive powers seemed particularly difficult for adult social workers who are more comfortable working with consent, in partnership with service users. Whilst some service users have been satisfied with the outcomes of use of statutory powers, many others, including carers, have expressed dis-satisfaction with interventions by social work professionals, often directed at the centralised, hospital-focused approaches to community support (Campbell and Davidson 2012). Risk-averse decision-making amongst ASWs in some areas was linked to lack of community resources. Rogers and Pilgrims (2001) highlight potential conflicts whereby in-patients sought more therapeutic approaches, but carers wished greater control to be exerted. In Scotland, social workers have increasingly been assigned leading roles, in legislation and interventions, for people with mental disorder whether as council officers, social work officers or as MHOs. Perceptions of the effectiveness of these roles are not widely researched, though MacKay et al (2011) in their study on the 2007 Act did obtain the views of social work practitioners. This study is explored later in this Chapter when examining the current legislative framework. These social work functions were not mentioned in the consultation for the Public Bodies (Joint Working) (Scotland) Act 2014 (Scottish Government 2012b)

and it is unclear how this legislation will impact on the independence of the MHO role.

2.8 Use of compulsion and ideas around risk

2.8.1 Introductory comments

As already discussed, UK social workers have an established role in the use of compulsory measures. The aim of social work involvement in mental health law is to ensure that welfare is at the heart of decision-making and to provide an external check on medicalised approaches associated with compulsion and detention. This is because social workers' training has a wider focus on welfare and rights issues than other disciplines and they are not usually employed within the health-based hierarchy of psychiatry (Maas-Lowit 2007).

This 'independence' helps bring rigour to risk assessment, which is at the root of decision-making around compulsion and detention. In the data-gathering stage of this thesis participants will be asked to consider their own and others' attitudes to risk, and how far this impacts on use of the legislation. The word 'risk' and associated ideas are open to wide interpretation, so this section briefly considers issues associated with risk in relation to this legislative framework.

2.8.2 Terminology

The word 'compulsion' will largely be used, as envisaged in the 2003 Act, namely compelling a person to comply with care or treatment. However, this term may also refer to other aspects of compulsion, such as compelling someone, under the 2000 Act, to accept a care package. Coercion, a term used in some studies has a similar meaning. Another frequently used word is 'detention', again used in the 2003 Act: to

describe preventing someone from leaving a hospital or place of safety (ss293–298). Neither the 2000 nor 2007 Acts formally contain the power to ‘detain’, though may in effect be used for that purpose. A common term used as shorthand for detention in hospital is ‘sectioned’. Although often used by professionals and service users, it will not be used in this discussion, as it is potentially value-laden and does not give appropriate weight to detention processes. Discussion around the justification for compulsion will be further examined in this section in an attempt to understand the theoretical basis under the current legislative framework. ‘Risk’, is a much more contested term and is used across the Scottish legal framework. The next sub-section looks at defining risk in this context.

2.8.3 Defining risk

In the 2000 Act the word ‘risk’ only appears ten times. On four occasions this relates to duties of the Office of the Public Guardian (OPG), the MWC and local authorities, (but oddly not health boards), to act where an adult may be seen as ‘at risk’. Of the remaining six, four relate to notification processes and two to involvement in research without consent. The 2003 Act refers to risk 23 times, mainly in the context of investigation or seeking compulsory measures. Assessment of risk underpins one of the principal criteria for emergency, short-term and long-term compulsion (ss36, 44, 57, 57A). The 2007 Act uses ‘risk’ 94 times, almost exclusively preceded by the word ‘at’. The 2007 Act uses terms such as: ‘adult at risk of harm’ (for example s3(2)) in defining an adult at risk); ‘adult at risk from serious harm’ (s41(2)) in relation to a sheriff’s duties in granting orders, or in the actual criteria for orders “an adult at risk is ...likely to be, seriously harmed” (s12(a)). Despite the apparent increasing pre-occupation with risk and the centrality of risk assessments, none of the Acts define risk or terms such as ‘significant risk’ or ‘serious harm’.

In the absence of a legal definition, previous legal decisions under other Acts might help and the dictionary definition may also be useful. It is important to consider how this concept is defined in literature. Some writers considered the increasingly risk-averse nature of society, and in so doing have attempted to define risk. Beck discussing societal attitudes to risk and the 'construction' of modern and post-modern societies provided the following definition of risk assessment: "a systematic way of dealing with hazards and insecurities, induced and introduced by modernisation itself" (Beck 1992 p21). Levitas (2000) disagreed and asserts that ideas of risk underpin capitalism; in that market forces or luck are the determinants of success. She argues that Beck examined the transition from 'class-based' to 'risk-based' society but forgot that there is a significant social underclass for whom there is no path to economic security. She suggests his pre-occupation is an academic one, which does not recognise the real-world situation of the disenfranchised, rather bluntly asserting that "self-actualisation is difficult when you are dead" (Levitas 2000 p206). She suggests that Beck's standpoint is fatalistic, implying, from a social welfare perspective, that market forces and risk must ultimately dominate. She argues for a 'transformative utopianism' which challenges this fatalism, instils hope and achieves wider acceptance of more radical viewpoints and greater transparency about risk.

Webb (2006), linking these ideas to social work practice, argues that as society progresses through modernisation into post-modernism, the emphasis has changed from a Victorian philanthropic approach, through a more empowering needs-led approach, to what he argues is now a much more risk-led approach. Titterton (2005),

reviewing a range of literature, also drew this conclusion, arguing that risk has replaced need as a main driver for change in approaches to delivery of social services. He suggests there are many unresolved tensions between risk and need, and risk management and empowerment. Echoing Levitas (2000), he also challenges Beck's (1992) and others' rather negative view of risk, suggesting that such generalisations about modernity, neither acknowledge the realities of day-to-day life nor encourage more positive ideas around 'risk-taking'.

Despite the apparent increased focus on risk in the legislative framework, which could be seen as encouraging risk-averse processes, the Acts do seem to promote positive risk-taking. Principles across the Acts require those exercising functions to consider least restrictive options, maximise benefit and, under the 2000 Act, explicitly require that any action taken will encourage use of existing skills and development of new ones (s1(e)). Willingness to tolerate risk would appear to be a pre-requisite to achieving such objectives. Robertson and Collinson (2011), from a small-scale study into learning disability and mental health community services, argue that positive risk taking is essential, despite anxieties for workers and the public. They emphasise the dangers of risk-averse approaches, making links to recovery principles and the need to look beyond medication. Whilst the legislative framework in Scotland may not be the radical challenge to capitalist power structures Levitas (2000) would espouse, the increasing push for real user involvement and robust criteria for compulsion, does challenge the 'hegemony' of psychiatry (Coppock and Dunn 2010) and is regarded positively by commentators (Atkinson 2006; Campbell et al 2006).

It is apparent there is disagreement about how risk should be defined and managed. For the purpose of this study, Alberg's definition is useful, concise and adopted by many writing about mental health law in Scotland (Loxton, Shirran and Hothersall 2010; Maas-Lowit 2010): "Risk can be defined as 'the possibility of beneficial and harmful outcomes and the likelihood of their occurrence in a stated timescale'" (Alberg et al 1996, in Titterton 2005, p25). Titterton (2005) argues that this closely aligns with risk management processes within social work. Loxton, Shirran and Hothersall (2010) suggest risk is likely to be regarded negatively in social work settings, arguing that the term 'risk' is often associated with danger and harm. This increasing tendency to risk aversion is linked to 'blame culture' associated with numerous inquiries into 'failures' in child or adult protection (Robertson and Collinson 2011; Loxton, Shirran and Hothersall 2010). The MWC concisely summarise the importance of risk-taking: "risk is a part of everyone's existence. Some degree of risk-taking is an essential part of good care" (MWC 2006d p7).

2.8.4 Assessing and managing risk: principles and practice

If there is debate about the definition and thereby assessment of risk, so too about management of risk. While risk management strategies are often complex and ill-defined, detention and compulsory treatment are clearly defined responses to risk. Campbell and Davidson (2009) observed that coercion is frequently the mental health professionals' response to risk, despite rhetoric around reciprocity and rights. They further assert that justification for compulsion generally utilises criteria based on risk thresholds, often tempered by views about the capacity of the person to take informed risks. This is certainly the case in Scotland where the criteria for compulsion refer to risk to health, safety or welfare under the 2003 Act and to risk of harm under the 2007 Act, in the context of impaired capacity or decision-making

ability. Neither guidance nor law in Scotland recommend use of specific risk management tools.

The 2003 Act specifically excludes acting “as no prudent person would” from being described as mental disorder (s328), thus freedom to take decisions, no matter how unwise, is protected under the 2003 Act, but the state’s duty to protect is also very clearly expressed across the legal framework. Webb (2005) highlights the change in societal attitudes from pre-industrial life, where choices, except for the wealthiest, were very limited and only promise of the afterlife provided some hope, to post-industrial society where the possibilities of fulfilment are much wider. Consequently, people expect to be ‘allowed’ to take risks to achieve their goals but are sometimes fettered by regulations and social norms. He points to a shifting emphasis from fatalistic attitudes to expectations that life will be protected: “salvation has been dethroned: healing has taken its place” (Webb 2005 p124). In considering support for the use of compulsion, social workers find themselves caught in complex ethical dilemmas between trying to respect the rights of individuals and protecting them from harm.

Castell (1991) explored ideas in relation to risk-averse society and professional responses. He asserted that care professionals are becoming ‘technicians’ who manage complex risk assessment frameworks. He highlights the shifting emphasis from individualised approaches and professional judgement, to more technical approaches involving ‘risk indicators’ intended to predict ‘deviance’, self-harm or risk to others. In considering risk and dangerousness, he notes how poor the predictors are and that these often amount to a set of ‘risk factors’, applied by rote, unrelated to

the individual or ‘his’ perspective on the world. He argues social care professionals lack the skills to undertake more ‘actuarial’ kind of risk assessments increasingly prevalent in social work.

Fifteen years later Webb (2006) made very similar points describing the bureaucratic processes which drive risk assessment and management as ‘technical rationality’. He sees this as a top-down approach, undermining social workers’ professional judgement and treating them as low-grade form-fillers, rather than professional decision-makers. He argues that social work management prefer ‘expert’ approaches to regulate risk. Loxton, Shirran and Hothersall (2010) similarly identify over-reliance on procedure and undermining of professional judgment. Titterton (2005) reported that participants in his training courses tended towards practice which focused on risk aversion and ‘back-covering’. Workers, he claimed, felt discouraged from adopting creative approaches as management feared law-suits for negligence, though he suggests managers might also be sued for *not* taking risks. Nevertheless, he emphasises that utilising law to manage and assess risk, not only protects management, but service users and social workers. With reference to use of compulsion, Campbell and Davidson (2009) highlight increasing preoccupation with public safety over individuals’ rights.

Titterton describes two simple categories for risk management strategies: the “safety-first model” utilising “defensive practice” that is covering one’s back, and the “risk-taking model” characterised by “defensible practise” namely taking professionally and ethically justifiable decisions (Titterton 2005 p82). Safety-first models focus on disability, danger and control, where risk-taking models reflect

ability, user involvement and take a holistic view of need and risk. Robertson and Collinson (2011) rehearse similar debates between safety and empowerment, concluding that undue emphasis on safety leads to risk of breakdown in relationships between service users and staff. Loxton, Shirran and Hothersall (2010) strongly emphasise the correlation between empowering approaches and the principles of the Scottish legal framework.

2.8.5 Summary

This section has alerted the reader to general debates around risk and the dilemmas for social workers in balancing the duty of care against empowerment. A legislative and procedural framework which provides direction in this regard and appropriate safeguards might be seen as helpful. Alternately the increasing emphasis on risk in Scottish legislation, and voluminous advice and guidance, may indicate that legislators seek to limit autonomy rather than encourage professional judgement. Participants' views on risk in this regard will be of interest when considering the credibility and interpretation of the law from their perspective.

2.9 The implications of, and findings from, inquiries

This section examines relevant themes and presents a detailed, critical summary of the twenty-seven MWC investigation reports dating from 2006 to 2016. Cross-references identifying commonalities with wider commentary, relating to UK-wide inquiries are highlighted. A few published reports predating the implementation of the 2003 Act have been excluded as these have less relevance to the current framework. The MWC is legally empowered to carry out investigations and make recommendations in terms of s11 of the 2003 Act. Publicly accessible reports are

prepared for the more significant investigations, which provide authoritative, at times critical, accounts relating to operation of the legislative framework. Recommendations typically include review of legislation and related policy and call for more guidance, better training or increased resources. All bar one of these investigations take the form of detailed case studies, often linked to wider issues. For example, *Justice Denied* (MWC 2008b), based on a woman subject to sexual violence, highlights the issue of people with learning disability struggling to make their voices heard in court processes.

2.9.1 Relevance to this study

Reviewing these reports adds depth to discussion of the legislative framework, and provides evidence of the challenges faced in implementing this complex suite of legislation, based on actual cases and the views of related stakeholders. These reports make a valuable contribution to understanding how the law is perceived by stakeholders, how far the framework is perceived to address risk and highlights obstacles faced by professionals in meeting legal and policy requirements. Some practice guides, published by the MWC have been prompted by these investigations, such as Right to Treat (MWC 2011a), linked to the death of Ms R in 2011 (MWC 2012g). However, these investigations lack the academic rigour associated with true empirical research, so the conclusions need to be treated with caution. In addition, these reports often relate to failures by medical professionals, not those carrying out social work functions. Nevertheless, understanding the challenges for medical gatekeepers may help to improve communication and co-operation.

2.9.2 Process of reviewing reports

Only brief details of the inquiries can be included here, but substantial space is nevertheless devoted to identifying common features and findings, grouped under

themes relevant to this study. It is acknowledged that there could be other narratives within the reports, particularly relating to the role of other professionals or user and carer perspectives. The context of each identified theme is briefly discussed and then illuminated with reference to a particular inquiry report, with cross references to other related reports. Methodological shortfalls are highlighted under the thematic heading where relevant and at the end a brief overall critique of the reports is presented.

2.9.3 Themes identified in inquiry reports

2.9.3.1 Lack of clarity about diagnosis and capacity, and lack of knowledge about conditions

This emergent theme recalls issues discussed in the review of literature related to diagnosis and treatment. Much criticism is levelled at medical professionals, though almost half the reports studied highlight similar failures in understanding amongst other groups, including social work staff. Ignorance of the law, or confusion over diagnoses, potentially impacts on the ability of those discharging social work functions to fulfil their duties and on their perceptions about the credibility of the law.

The case of Ms MN (MWC 2016a), who committed suicide in 2013 at the age of 44, exemplifies many issues identified under this theme. The MWC notes she was originally diagnosed with dependent personality disorder, later with schizophrenia and then with Asperger's syndrome. Even when she died, the consultant involved with her for many years recorded a primary diagnosis of schizophrenia with a secondary diagnosis of Asperger's, whilst forms related to compulsory treatment, hospital staff and the discharge letter completed by a junior doctor, referred to alcohol dependency with Asperger's as primary diagnosis. This latter view would

appear to be borne out by the fact that in MN's last year she was mainly prescribed minor tranquilisers as opposed to anti-psychotics. In early 2012 long standing attempts to support her at home were abandoned in favour of hospital admission, followed in November 2012 by a move to a care home which largely accommodated people with learning disability. Throughout her contact with services, she presented very difficult to manage behaviour, including verbal and physical aggression. Whilst in hospital she made four attempts on her life, but apparently this was not communicated to the care home and within six weeks of being admitted she had taken her own life. The MWC raised many issues around this case, but particularly highlighted the negative impact of changing diagnosis and asserted that people diagnosed with Asperger's often seem to be side-lined by services. The investigation found that the care home had little knowledge of Asperger's, that her capacity was not properly assessed and consequently her needs were not adequately addressed.

The Mrs CD report (MWC 2014d) also referred to disagreement over diagnosis and asserted that health and social care services' mistaken belief that she had personality disorder, led them to "abandon her to her fate" (MWC 2014c p14). Mrs CD was initially imprisoned, rather than treated for depression, which the MWC believed should have happened much earlier. In another case, Mr O killed himself following several suicide attempts, all of which were attributed by service providers, to alcohol and drug use, yet he was prescribed quetiapine and carbamazepine treatment for psychosis and mood disorder (MWC 2012e).

Several reports cited lack of knowledge about conditions, such as alcohol-related brain damage (ARBD) (MWC 2006b), dementia (MWC 2007c) and forensic psychiatry (MWC 2006c). Similarly, many reports referred to lack of knowledge about

capacity and use of simplistic assessments (MWC 2016a, 2010b, 2007b, 2007c). In two cases these poor assessments led to failure to intervene and ultimately avoidable and premature death (MWC 2010b, 2007c). Two reports highlight reluctance to respond to referrals, until too late, by which time significant harm had occurred. One of these highlighted failure to diagnose major mental illness (MWC 2014e, 2014h). Two other reports refer to service providers' assertions that the person concerned was making lifestyle choices rather than lacking capacity, again leading to failure to intervene until it was too late (MWC 2008a, 2007b).

These reports reinforce findings highlighted earlier in the review of literature, that agreement on psychiatric conditions is lacking and treatment responses vary considerably. In many cases the MWC assert that opportunities to intervene using the legal framework were either missed or delayed, highlighting inconsistent application of the law. The reports do not identify geographical areas, so it is not possible to correlate the differential use of law highlighted with available statistics.

2.9.3.2 Failure to use proper procedures

Poor record-keeping and failure to utilise legal procedures and related processes, such as the Care Programme Approach (CPA), are recurring themes in these reports. The legislative framework lays out clear expectations about interagency communication, particularly around risk, but despite this, evidence from these reports suggests that practitioners still circumvent legal processes in favour of less formal approaches. These findings link directly to participants' beliefs about the credibility and interpretation of the legal framework, particularly about the utility of the law.

The AB report (MWC 2013c) typifies the range of concerns raised by the MWC about failure to adhere to process, so much so that in this case they opined that unlawful deprivation of liberty had taken place. The MHO and physicians, including a psychiatrist, mistakenly believed that s47 of the 2000 Act, alongside consent of the Welfare Attorney, provided sufficient grounds to transfer AB from a general hospital to a psychiatric unit, to enforce sedation and to prevent her from leaving hospital. S47 authorises, rather than enforces, treatment where the patient lacks capacity and should not be used to underpin compulsory hospital admission (Patrick 2008), even with the consent of an Attorney. Cot-sides were used to prevent AB from leaving the ward, contravening long-standing MWC guidance on restraint, which makes clear these should only be used to prevent people from falling out of bed. When used to prevent someone from leaving a ward, an unlawful deprivation of liberty is likely to occur (MWC 2006d). A surprising, if poorly supported finding, was that many staff including the lead doctor did not believe the 2003 Act applied to “confused elderly people” (MWC 2013c p14). The MWC viewed the initial move to hospital as justifiable under common law, but asserted that recording of the reasons for this decision, and records relating to administration of medication, were inadequate.

At least seven other reports identify failure to use proper legal procedures, briefly detailed as follows. Ms Y (MWC 2008c) was detained in an adult unit despite being only 16, without use of formal processes under the 2003 Act, or due consideration of other options, both legal requirements for those under 18 (s23, the 2003 Act). During Ms L’s stay in a private hospital (MWC 2008a) the MWC identified 426 ‘adverse incidents’, none of which resulted in critical incident review processes or use of formal detention. The MWC (2008b) believed Ms A’s care plan was unduly restrictive

and should have been underpinned by Guardianship under the 2000 Act. In the same case failure to use criminal law to deal with perpetrators of abuse against her was also criticised. The MWC attribute Mrs I's premature death (MWC 2010b) to failure to utilise the 2003 Act or existing power of attorney arrangements. In Mr N's case, the day after a tribunal imposed a hospital-based CTO, he was allowed out on suspension of detention, without follow-up from community services, and he killed himself two weeks later (MWC 2012f). Similarly, despite being subject to the 2003 Act, Ms Z (MWC 2010c) was reportedly provided with inadequate follow-up when discharged from hospital and killed herself within two days. Some cases identify misuse of existing powers, such as Mr and Mrs D who had a learning disability (MWC 2012h). Mr D's brother used his position as Power of Attorney to financially and emotionally abuse Mr D and his wife over a six-year period. Furthermore, the MWC believed these powers were granted following several failures of process between the GP, solicitor and care services.

Several reports (including MWC 2012e, 2010b, 2009d, 2007b, 2006b) refer to failure to use processes relating to adults at risk of harm, inadequate multi-disciplinary decision-making or failure to use the CPA. These are not specifically legal duties but nevertheless processes which are clearly laid out in guidance documents and codes of practice. The inquiry into Ms V (MWC 2011b) identifies failings in internal hospital processes, whereby she was effectively starved to death and administered excessive amounts of sedation. Mr JL was denied appropriate end of life care due to failure to recognise the impact of his limited capacity and poor adherence to multi-agency processes (MWC 2014f). The report on Ms R (MWC 2012g) on the other

hand made reference to good use of multi-disciplinary processes in the early stages, but identifies failures in anticipatory care planning in the end stages of her life.

It seems this failure to utilise due process has arisen from preference for informal approaches and in some cases ignorance of legal and procedural requirements. Whilst much of the evidence in these reports relates to actions of medical or nursing professionals, many of these decisions were taken in a multi-agency context and as noted earlier, lack of commitment to these processes from medical staff potentially undermines the ability or motivation of those discharging social work functions to act within the law.

2.9.3.3 Failures in communication

Communication failures are common to nearly every inquiry undertaken and have frequently led to negative outcomes (Stanley and Manthorpe 2001; Reith 1998). The Scottish legal framework does attempt to promote good communication, indeed the 2007 Act explicitly demands cooperation between authorities (s5), however, the MWC investigations suggest this is not working. Many of the reports make reference to poor record keeping, poor inter-agency communication and poor communication with service users and carers. In coordinating adult protection inquiries, local authorities are expected to demonstrate a high standard of communication with stakeholders (Scottish Government 2008b), but these reports suggest that where communication is lacking, there is likely to be a negative impact on the ability of the local authority to fulfil its duties. In terms of this thesis these reports call into question how far the law helps to ease communication and what impact this may have on practitioners' beliefs about the legislative framework.

The L and M inquiry (MWC, 2006c) pointedly criticises NHS staff for failings in internal communication and communication with Government, in relation to a high profile offender (Mr L), who was subject to restrictions under mental health law. Mr L, arguably very poorly monitored, was discharged from hospital in April 2003 and went on to kill Mr M, another patient, in October the following year. This incident and subsequent reports led to significant changes in the way that NHS and social work mental health services deal with mentally disordered offenders.

Many reports identify disagreements over responsibilities, between NHS, social work and housing authorities (MWC 2016a, 2014c, 2014d, 2014h, 2012e, 2008b). In all of these cases, failure to communicate was seen to be a major problem and in some cases this was seen as deliberate, whereby unilateral decisions were being taken by consultants. Reith (1998) found evidence that psychiatrists, often at the head of decision-making chains, were frequently not engaged with others' perspectives, weighting information received on the basis of their perception of that person's status.

Reviewing UK inquiries Reith (1998) and Stanley and Manthorpe (2001) emphasised the need for improved communication across all partner agencies and highlight widespread failures in information sharing and complexities around confidentiality. Reith (1998) identified a specific case of, apparently preventable, suicide where police and social work failed to disclose information to a person's psychiatrist. The MWC inquiry into Mr GH (2014h), noted that his partner and Criminal Justice services withheld valuable information, from the GP and other medical practitioners, resulting in very serious consequences. Ms DE committed suicide after an

assessment relating to Employment and Support Allowance had turned down her appeal. No communication occurred between the DWP and mental health services (MWC 2014j).

2.9.3.4 Managing risk

The earlier part of this review of literature makes clear that managing risk is core to mental health law and that failure to manage risk has very serious consequences, echoed in most UK official inquiries (Stanley and Manthorpe 2001; Reith 1998). The Scottish legal framework, promotes pro-active and integrated involvement of services in addressing issues of risk. Policy documents support this approach, for example 'Closing the Gap' (Scottish Government 2007c) calls for coordinated, assertive approaches to dual-diagnosis (substance misuse and mental illness). Again a clear link with this thesis is evident, in this case around the credibility of the legislative framework, in supporting decision-making around risk.

Many MWC reports identify problems around risk, often related to lack of assertive risk management approaches. In the Mr H case (MWC 2006b) the 'passivity' of medical staff resulted in failure to communicate risks to social work. Mr H had ongoing alcohol problems and was later diagnosed with Alcohol Related Brain Damage (ARBD). He had been subjected to repeated financial and physical abuse and had been known to social work since the 1980s, but consistently refused assistance, due in part to his daughter's negative influence. Only when he was admitted to hospital in 2004 did the level of abuse and neglect become clear, whereupon the local authority sought welfare guardianship. Recommendations urged social workers to take a more assertive approach to involving psychiatry, which seems to place the burden of responsibility in the wrong place.

The Ms L case refers to failings at management level, suggesting adverse incidents were not acted on and reports seemed to “take place in a vacuum” (MWC 2008a p13) One commonly reported finding, explaining inadequate risk processes, was over-familiarity with the patient, a factor also identified in UK-wide inquiries (Reith 1998). “Too Close to See” (MWC, 2009d), outlines the circumstances of Mr F, a 41 year old man with chronic schizophrenia and alcohol related problems. He lived with his abusive father, who he eventually killed, yet his home situation was not seen as a major risk and anger problems were inadequately addressed. Lack of robust, structured, risk assessment processes was attributed to ‘over-familiarity’ of staff with Mr F’s circumstances and failure to involve colleagues from social work and other disciplines. In the Mr S case (MWC 2014b) over-familiarity led to a tolerance of escalating criminal behaviours and wrongful imprisonment of a man with learning disability, attributed to lack of formal risk assessments. MWC inquiries into the suicides of Ms Z (MWC 2010a) and Ms MN (MWC 2016a), assert that both were well known to staff, leading them to underestimate the risks. The Ms OP case highlighted circumstances where risks related to previous post-natal depression were not taken into account and she went on to suffocate her 9 month old child (MWC 2016b). Even where risk plans were in place, for example in Mr Q’s case (MWC 2009c), risk assessments were neither explicit, nor frequently enough revised, ultimately resulting in serious assaults. At managerial level the L and M case (2006c) highlights similar failings in risk planning and management.

2.9.3.5 Personalisation and user involvement

Another broad theme emerging from the MWC reports relates to availability of specific individualised resources. Underpinning principles and processes in all three

Acts place great emphasis on user involvement and person-centred approaches, so these findings give some indication as to the effectiveness of the legal framework in meetings these aims, important if the framework is to achieve credibility with practitioners.

Several reports highlight lack of appropriate resources, notably Ms L (MWC 2008a). This young woman with learning disability and possibly autism, reportedly presented very challenging behaviour. She was moved from one hospital to another resource, which NHS staff saw as inappropriate, to yet another unspecified location. The report states no unit in Scotland could meet this young woman's needs. The Ms MN report (MWC 2016a) and the Mr Q report (MWC 2009c) both highlight similar issues about lack of appropriate care facilities for people with severe autism and learning disability.

The one investigation which deals with more generalised circumstances of a particular group, "A Recipe for Abuse" (MWC 2009b), highlights situations where people with learning disability or mental illness, until very recently living in unregistered hostel type accommodation, were reportedly subject to frequent sexual and physical abuse. Scottish Government statistics show that although such hostels now need to be registered, numbers of homeless due to mental health problems increased by over 20% between 2014 and 2016. The overall percentage of homelessness in Scotland increased from 4000 in 2002 to 10,000 in 2010. Whilst placement in hostels now slightly outnumber those in bed and breakfast, the overall percentage in temporary accommodation between 2013 and 2017 consistently remains at about a third of the total (Scottish Government 2017). Government

statistics do not specify the background of that group, but numbers discharged from institutions also remain static, suggesting that the situation is unlikely to have improved much for those with mental disorder.

2.9.3.6 Influence of relatives

The legislation sought to enhance the role of carers, not least through the principles. For example, all three Acts require views of relevant others to be taken into account by those discharging functions (s2(c) the 2007 Act; s1(3)(b) the 2003 Act; s1(4)(b) the 2000 Act). It might be expected that the MWC reports would focus on shortfalls in supporting relatives, however, many highlight negative influences of relatives and even where the MWC was supportive of the relative(s) concerned, their influence on care arrangements could still be viewed quite negatively.

Mr Q's (MWC 2009c) situation particularly exemplifies the rather conflicted views noted above. This report highlights the hospital's apparent failure to manage risks associated with Mr Q, who "with little obvious benefit to him" (MWC 2009c p4) was an in-patient for 4 years. Mr Q had autism and presented very challenging behaviour, requiring detention under the 2003 Act, involving considerable restriction of his liberty, throughout his stay. Mr Q's mother's influence might be seen as negative, albeit probably well-intentioned. She complained frequently, and at every level, about multiple aspects of his care. Prior to admission, Mr Q attempted to strangle, and threatened to kill, a female nurse and had seriously assaulted a female doctor (alongside another eight incidents of violence and sexual assault). He was restricted on the ward for his own and others' safety, based on the RMOs decision that contact with a female speech language therapist posed high risk. Over a prolonged period his mother challenged these restrictions on the grounds that he was too restricted. A

contemporaneous clinical psychology report argued that she did not meet the 'young female' profile of his victims. The RMO eventually allowed some relaxation of the restrictions, though retained a requirement preventing access to women, but within three weeks Mr Q had launched an unprovoked attack on a female member of staff, causing her severe injury. Throughout his admission there was an oppositional relationship between his mother and the services, such that the local authority opposed her application for welfare guardianship and the RMO refused to engage with her. The report is critical of the hospital for contravening their own risk plan and putting Mr Q at risk, but nevertheless acknowledges undue pressure on staff on busy wards and lack of resources to support effective observation and supervision (MWC 2009c). He was finally returned to the care of his parents, a move opposed by professional staff, although all concerned agreed the hospital environment was not ideal.

Five other reports cite the unfortunately negative and at times exploitative nature of relationships with relatives. In Mrs I's case (MWC 2010b conflict between relatives and the statutory services apparently contributed to failure to act and protect. Mr H's (MWC 2006b) daughter appears to have financially and physically abused and neglected her father. Mrs T's son (MWC 2007b) reportedly used considerable brutality and cruelty in exploiting and abusing his mother. Although Ms L's mother (MWC (2008a) was viewed as very loving and supportive of her daughter, her intervention to block certain medicines, alongside her objections to physical restraint, may well have contributed to difficulties hospital staff experienced in managing her very challenging behaviour. As highlighted earlier, Mr F (MWC 2009d) was left in the

care of his abusive father for much of his adult life and has now been convicted of his murder.

The Clinical Resource and Audit Group (2005), cognisant of failings in hospital risk management processes, provide useful practice guidance, emphasising the importance of effective dialogue with patients and carers in relation to management of high risk patients. The MWC reports, albeit a small sample, highlight significant problems in this regard, and suggest that the legislative framework may not be achieving key objectives around involvement of relatives.

2.9.3.7 Discrimination

MWC reports routinely remind the reader of the importance of combatting discrimination, in relation to explicit principles in the 2007 and 2003 Acts (Sections 1 and 3 respectively). The following reports repeatedly assert that contrary to these principles, service providers have acted in a discriminatory manner.

In Mr O's case (MWC 2012e) a CMHT justified their minimal involvement on the grounds that his behaviour related to drug and alcohol use. However, the MWC make clear he had pre-existing developmental problems, including Attention Deficit Hyperactivity Disorder. Following a ten-day admission relating to an overdose in early 2010, Mr O (MWC 2012e) was allowed to discharge himself. Following a further overdose two weeks later, when he refused hospital admission, he was sent four appointments to see a CPN over the next six months, none of which he attended. Viewed as uncooperative, his drug use was identified as a barrier to engagement and after no further contact, he hanged himself. It appears no

consideration was given to visiting him at home, which, oddly, the MWC fail to even mention in their recommendations.

This failure of services to engage was further demonstrated in four other cases. In Mr H's case (MWC 2006b) this was attributed to discriminatory attitudes of service providers towards alcohol use and undue influence of his daughter. Mr G was viewed by service providers as "difficult and challenging" (MWC 2007c p36) despite a range of diagnoses that merited intervention. The Ms A report notes that, like many others with learning disability, she was not afforded "her basic right to equal protection under the law" (MWC 2008b p66). In Mrs I's case (MWC 2010b), citing age discrimination, the MWC argue that a younger person would not have been allowed to descend into a state of such neglect. Discrimination in respect of people with mental disorder is cited in the EF case (MWC 2014c), whereby insufficient attention was given to his physical well-being resulting in his premature death.

2.9.4 A critical examination of MWC reports

As noted at the outset these reports are not undertaken with the rigour of academic research or the gravitas of court processes, so inevitably perhaps subjectivity and looseness of language is apparent. Furthermore, there is a common thread through these reports focussing almost exclusively on identifying failure and shortfalls rather than highlighting good practice where it occurs, albeit these are obviously inquiries prompted by poor outcomes. In some of the reports the language does not seem constructive and may lead to defensive practice (Titterton 2005). There are also matters of accuracy in relation to several of these reports. The following section identifies three areas of concern in these inquiry reports, namely inaccuracies, mixed messages about key issues and apparent partiality. These aspects serve only to

undermine, often valid, points made in the reports and potentially damage relationships between the regulator and those charged with applying a complex and at times inconsistent legislative framework.

2.9.4.1 Inaccuracies or contradictory information

The MN report (MWC 2016a) contains factual errors (for example it refers to her committing suicide seven weeks after admission in one part (p21) but six weeks in others (p27, p31). The poor structure of the report makes it hard to extract important points. The MWC devote almost a page to their view that Guardianship under the 2000 Act could have been used to enforce a community care package, referring to s70 which allows applications to the Sheriff to enforce a guardian's decisions. The psychiatrist's reported view that MN did not lack capacity, is not explored, nor is it acknowledged that it is impractical to use of s70 to enforce entry, where enforced access is potentially needed on a daily basis. The report claims this has been used to support care packages, but cites very generalised examples.

The Mr Q report (MWC 2009c) also contains inaccuracies. The report is generally very critical of health services, but incorrect assertions that doctors were not following the protocols of the 2003 Act in relation to the renewal of his detention in February 2005, undermine the report's credibility. The 2003 Act was not implemented until October 2005. The report further states that the first multi-disciplinary meeting took place, following a tribunal, in November 2007 (MWC 2009c p10), contradicting an earlier statement that two such meetings took place in July and August 2006 (ibid p7). When his mother appealed the detention, it is reported that the tribunal decided to send him to a medium secure unit (ibid p9) rather than return him home with an intensive community care package, a decision which she

appealed to the Sheriff Principal. The tribunal has no power to send someone to a secure unit and publicly available court documents (Scottish Courts 2007) demonstrate that the Tribunal simply preferred the evidence of the RMO and MHO that a hospital-based option should be imposed. The community option had apparently not been laid out in any detail. Despite emphasis on this only a very minor element of the appeal was upheld and he was not released from hospital until a later tribunal.

The *Justice Denied* report (MWC 2008b) asserts that no-one was ever taken to court (s1.1.7) for sexually assaulting her, yet narrative in the same report notes that one man was charged and convicted in 1978 (s2.3.5) and in 2000 a man who was charged and taken to court suffered 'significant brain damage' before the prosecution was completed (s2.7.13). Two reports cite alleged failure to use vulnerable adult processes, despite the fact that both pre-date the processes by over a year (MWC 2007b, 2006b). The Mr H report (MWC 2006b) further criticised lack of knowledge of the barely used National Assistance Act 1948. Furthermore, the Mr H report significantly underplays the fact that his main problem was alcohol related and therefore outwith the scope of either the 2000 or 2003 Act. It was only following diagnosis of ARBD that compulsory intervention was possible. Elsewhere in the Mr H report spelling errors in a support worker's notes are highlighted with no apparent relevance to the inquiry.

2.9.4.2 Partiality

In the Mr Q case (MWC 2009c) the only professional involved who seems to have been in agreement with Mr Q's mother was the clinical psychologist, yet the MWC report is completely uncritical of the mother's role in this case, despite her clearly

oppositional relationship with social work and NHS. Contrastingly, the report seems disproportionately critical of health and social work professionals involved. Given the report repeatedly expresses frustration with the RMO's demonstrable long-standing non-cooperation with the MWC, there could be a subjective element to this wider criticism.

In the analysis of the Ms MN case (MWC 2016a) the MWC claim that there was a high risk of suicide, but this did not accord with the RMOs view. Their criticism that the care providers were not given a sufficiently robust plan to deal with suicide risk may be simply the benefit of hindsight, furthermore, detailed MHO and psychologist reports, both containing information relating to risk of suicide, were held by the care providers.

Mr and Mrs D, a couple with mild learning disability, appointed an attorney, who went on to abuse them over a period of five years (MWC 2012h). The MWC severely criticised the local authority and urged it to issue a formal apology for failing to seek removal of the attorney under s10 of the 2000 Act: "The local authority should have intervened at a much earlier stage ... they allowed an abusive situation to continue unchecked for a number of years… the Ds would have difficulty in revoking the powers, not least because they lacked the capacity to act due to their learning disability" (MWC 2012h p13). This last point is put forward as fact, despite information presented elsewhere in the report that the OPG refused to investigate because Mr D apparently 'had' capacity according to the assessing psychiatrist. Failures by the GP and solicitor to follow due process in arranging these powers is excused on the grounds that inadequate guidance was available (p64), yet the

Codes of Practice for Attorneys (updated in 2011), provides extensive guidance and was readily available at the time (Scottish Government 2011b). The community learning disability team had provided Information relating to inappropriate behaviour of the proposed attorney, but the GP did not read it. Despite lack of cooperation from the OPG and medical staff the local authority was eventually able to help the Ds to revoke the appointment themselves. To accept this revocation, the OPG would need to be satisfied that they had the capacity to make this decision, despite assertions by the MWC to the contrary. The emphasis on the local authority's culpability seems disproportionate; no such criticism is directed at the psychiatrist, GP, OPG or solicitor.

2.9.4.3 Mixed messages

Ms R was subject to local authority guardianship, but was allowed to decline investigation and treatment in relation to cervical cancer, ultimately resulting in her untimely and painful death (MWC 2012g). The MWC acknowledge that decisions about enforcing physical treatment are poorly supported by policy. The 'Right to Treat' guide (MWC 2011a) produced by the MWC to try to help with this, puts forward two case examples, where s47 or Welfare Guardianship should be used to enforce treatment, contradicting their position in the Ms R case that it was the correct decision not to enforce treatment. It is also notable that the report praises the care team for processes leading to non-intervention in the early stages but criticises the lack of an anticipatory care plan at the end of her life.

In *Justice Denied* (MWC, 2008b), the MWC highlights risk of sexual assault and failure to properly assess Ms A's capacity. The MWC clearly believed she was incapable of entering into sexual relationships due to her learning disability, though it

is less clear how they believe this should have been dealt with or for that matter how conflicting evidence in this regard was assessed. The report criticises “the absence of … multidisciplinary consensus about issues of personal autonomy and capacity to consent to sexual activity” (MWC 2008b p57), but later rather contradictorily asserts that the assessment of her capacity to enter into sexual relationships is “the responsibility of medical staff … something which medical staff had done and been in consistent agreement on for over 30 years” (MWC 2008b, p71). The report confuses matters further noting that in 2007, “GP1 wrote to Psychiatrist 4 stating that ‘in my opinion Miss A does have capacity to make decisions regarding her health and welfare’” (MWC 2008b p46). The report recommends that Health and Social Work services should provide multi-agency training on capacity and consent in relation to sexual activity, but little guidance is offered on how this should be approached. Much later the MWC released *“Consenting Adults?”* (MWC 2012d), a rather complex practice guide aimed at addressing issues of consent to sexual activity. The only reference to the *Justice Denied* report, repeats the erroneous stance that no charges were ever brought against perpetrators of abuse.

The Mr A report (2012j), is intended to highlight commonplace issues in supported housing projects. Mr A, reportedly, “enjoyed a drink”, was struggling to care for himself and frequently set off the fire alarm in his sheltered house. He was referred to social work in mid-2009, was seen by his GP in early 2010 and was admitted to psychiatric hospital in June 2010. The report asserts that a more assertive approach by housing staff was required and wide-ranging recommendations include the need for a chronology, joint protocols, training and improved computer systems. These may well be helpful, but there is little recognition that reports of fire alarms going off

in sheltered housing projects are probably quite frequent and up until this point he appeared to have been living quite independently. There is a mixed message here whereby the report appears to be advocating quite an intrusive approach when matched against the key principles of the Act in relation to user choice, involvement and least restriction. Nothing is recorded about Mr A's own view of the situation, his right or indeed his capacity to make unwise decisions.

2.9.4.4 Taking forward concerns

In the foreword to most reports the MWC points out that it is a core function of these reports to take forward concerns, as typically stated in the Mr Q report (MWC 2009c, p1): "We gather information about how mental health and adults with incapacity law are being applied. We use that information to promote good use of these laws across Scotland". However, there are many issues noted above which do not seem to have been pursued by the MWC.

Nearly every case examined criticises NHS and social work services for failing to use the CPA, in place since 1996 (under guidance associated with the Mental Health (Patients in the Community) Act 1995). However, the MWC have released no practice guidance or undertaken any public lobbying of the government to promote its use. Since the L and M report (MWC 2006c) the CPA has been routinely used in forensic psychiatry, but otherwise there is no evidence to suggest its use is expanding.

In Mrs V case (MWC 2011) a medical care pathway for psychiatric wards is suggested, but again seems not to have been followed up by the MWC, this despite the fact that Government policy specifically requires hospitals to consider the

physical health of psychiatric patients (Scottish Executive 2006a). Interestingly the Mrs I report (MWC 2010a) urges the creation of a dementia care pathway though in fact this already existed at the time.

Given repeated criticism in these reports of NHS Board's and local authorities' failure to meet the needs of people with autism, there is little evidence of any effective lobbying by the MWC to improve this situation. The MWC five-year strategic plan (MWC 2012) acknowledges the lack of suitable hospital provision for young people with learning disability or mental illness, but makes no mention of autism, alcohol - related brain damage or any other of the complex conditions which these reports, quite rightly, suggest need to be addressed.

Perhaps in response to perceived criticism of advice given, later MWC reports provide statistics about advice-giving. Their 2011/12 report notes that 50% of advice related to the 2003 Act, 20% to the 2000 Act and that 33% of calls were from users or carers, suggesting that 67% were from professionals seeking guidance. The MWC claim that, of 3,772 callers who sought advice "we audited the accuracy of the advice given and found 97% of it was accurate" (MWC 2012g p36). Given that many commentators refer to the complex, and at times vague, nature of the application of mental health law, it is difficult to see how this claim about accuracy can be sustained. The reader is simply invited to accept this without any indication as to the mechanism to determine accuracy. The MWC does promote good practice through its website and contact with many service providers, but the goal of influencing policy following these reports does not always seem to be pursued.

2.9.5 Summary

Several issues have become apparent from this review of MWC reports. As already noted the MWC reports lack objectivity, at times, perhaps reflecting the views of the authors of the reports, and at others, give undue weight to particular issues or to the views of those interviewed. Reith (1998) had expressed a preference for more high level inquiries, chaired by high court judges or other prominent legal experts, but nevertheless reported similar criticisms of the processes, particularly about over-reliance on the benefit of hindsight. Nevertheless, these less formal MWC reports provide a valuable longitudinal perspective on usage of the legislative framework and highlight complexities involved in applying the measures in real life situations. It seems that issues of risk remain challenging, despite the preoccupation with risk in the legislation. Legal processes and related policy imperatives, such as the CPA do not seem to be embraced and at times seem to be actively avoided. Lack of resources to support the legislation seems to be a continuing problem. How far the role of relatives has been enhanced is not clear, though many reports seem to refer to the negative influence of sometimes exploitative relatives, rather than the benefits of involvement of carers and relatives. That said it is acknowledged that these reports focus on situations where things have gone wrong, so clearly underplay positive aspects of usage of the law.

Analysis of this small, but detailed, sample highlights some key debates around use of the law, linked closely to the aims and objectives of this thesis. Another important point for this study relates to the influence of powerful regulators such as the MWC. Their claims of 97% accuracy seem rather defensive at best, so if the criticisms are viewed as unfair or inconsistent and if the regulators are feared rather than regarded

as supportive, practitioners may be wary of the MWC. This may in turn mean practitioners are less inclined to seek advice and may lack confidence in the interpretation presented, when considering how to apply the law. Such criticisms potentially reinforce a ‘blame culture’, despite statements in several reports, such as the Mr N report (MWC 2012f), asserting that the MWC does not seek to apportion blame. It will clearly be important to establish the views of participants as to the role of the MWC and their experience of working with them.

This review of inquiries has highlighted important questions and issues around the use of mental health and incapacity law, which provide a valuable baseline from which to examine participants’ responses. Such detailed analysis of the operation of the legal framework in Scotland is not available in any other literature. Where commonality with participants’ perspectives is identified, validity and depth will be added to the findings of this thesis and provide support to the critiques presented in these inquiries. Views of participants which are not reflected in these inquiries may be areas worthy of further investigation.

2.10 The development of the Scottish legislative framework

2.10.1 Introductory comments

This section explores perceived problems with the previous legislative framework, as a backdrop to reviewing the current framework. Where appropriate, reference is made to developments in other countries. Broad headings related to the current framework will be used to aid clarity.

2.10.2 Adults with incapacity

The Scottish Law Commission (SLC) Report on Incapable Adults, published in 1995, brought together a wide range of stakeholders, including the aforementioned Adrian Ward, to address the need for reform, citing the United Nations Declaration on the Rights of Mentally Retarded persons as a key driver. The report provided detailed proposals for reforming incapacity law, highlighting the confusing array of measures to manage the affairs of 'incapable adults' (a term subsequently reframed as 'adults with incapacity'). Existing laws and measures were viewed as complex, poorly interrelated and not fit for purpose. These included tutors dative, tutors-at-law, powers of attorney, curators bonis and guardianship. The proposals resulted in the 2000 Act which specifically addressed matters of incapacity and was the first major piece of legislation enacted by the Scottish parliament.

Stalker, Duckett and Downs (1999) identified issues concerning learning disability and old age as driving forces for UK legislative reform. Following on from studies by Walker, Walker and Ryan (1996) they undertook in-depth research into co-existing dementia and learning disability, focused on 20 individuals. Where possible the person, their relatives and involved professionals were interviewed, and conclusions were drawn suggesting how professionals should approach assessments and interventions. Attitudes towards this group were seen to vary, whereby some took a rights-based perspective, whilst others believed this group could make no choices and needed others to decide. Making adequate time for communication, offering choice and involving people in decision-making were key recommendations. The 2000 Act and associated guidance attempted to address these important issues.

2.10.3 Mental health law in the UK

The 1995 conference '*Consensus for Change'*, focused on the overwhelming impetus for change in the 1984 Act, was described by Atkinson (2006) as a watershed, which signalled the separation of approaches in Scotland from the rest of the UK. The reforms which resulted in the 2003 Act were rather more convoluted than those for the 2000 Act, though certainly not as controversial or protracted as similar reforms elsewhere in the UK. The Richardson review of the 1983 Act in England and Wales (DoH, 2000), described by Grounds (2001 p387) as "a profoundly illiberal document", struggled to attract broad support and generated considerable controversy around definitions of mental disorder, particularly personality disorder. Grounds (2001), argued that safeguards against inappropriate admission and unduly lengthy detention were inadequate. After considerable debate about the purpose of mental health and incapacity law and several redrafts, the new MHA 2007 and Mental Capacity Act 2005 (MCA 2005) were eventually enacted. In Northern Ireland the 'Bamford Review' established in 2002 published a consultation paper (DHSSPS 2007), seeking to bring in similar measures, but as yet the Mental Health (Northern Ireland) Order 1986 (MHO 1986) remains the only legislation dealing with mental disorder and incapacity.

In Scotland, The Millan Committee was established to review the 1984 Act, publishing its report in 2001 (Scottish Executive 2001c). Atkinson (2006) argues that there was no political agenda in Scotland and that the Scottish parliament received this report positively, published an associated policy document (Scottish Executive 2001d) and included the majority of recommendations, when putting forward the 2003 Act for Royal Assent. The debates in the Millan Report (Scottish Executive

2001c) reflect the wider discussion prior to the introduction of the new legislative framework in Scotland. This report is still cited to help explain the intentions underpinning the 2003 Act, so broad headings from the report are used below to examine the developing agenda which led to its creation.

2.10.3.1 Addressing issues of Community Care

As already discussed the 1960 Act attempted to regulate treatment, put in place appeal procedures and began to define a central role for social work, but was nevertheless still grounded in medical approaches. The 1984 Act strengthened the role of the MHO and the MWC (Atkinson 2006) and also raised expectations around after-care (s8), formalising leave of absence arrangements to allow community-based compulsion (s27). The Millan Committee (Scottish Executive 2001c) found 'after-care' to be poorly defined, and not fit for purpose given that most people with mental disorder received care and treatment out of hospital. Recommendations urged improvements in detention procedures, and clearer processes for community use of compulsion or alternatives to compulsion which respected the rights and needs of patients and carers (Scottish Executive 2001c). According to Atkinson (2006) many user groups perceived community treatment as an invasion of privacy, stating that if they were ill enough to need treatment they would prefer hospital. Arguably Millan's view that community treatment is always less restrictive than hospital treatment (Atkinson 2006), reflects earlier discussed concerns around rigidity of thinking associated with the Scottish Executive's policies to shut down all long-term learning disability hospital provision (Scottish Government 2013b; Scottish Executive 2000a).

The 1984 Act itself was subject to many amendments but continued to be viewed as hospital rather than community focussed (Adrian Ward cited in Atkinson 2006). Frank Dobson, Secretary of State for Health at the time, succinctly highlighted perceived problems with community care. “Community care has failed. Discharging people … has left many vulnerable patients trying to cope on their own… a danger to themselves or a nuisance to others. A small but significant minority has become a danger to the public as well as themselves” (DoH press release 1998 in Bean 2001). Bean (2001) argues that community safety is important but is only one aspect of a much larger picture. The Millan recommendations tried to address this in Scotland, at least in relation to criminal procedures and the mentally ill, taking account of existing law in Scotland and of laws elsewhere in the world (Scottish Executive 2001c). Millan also acknowledged the parallel SLC work on implementing the 2000 Act, arguing that consistency between the two Acts was important and recommending that ultimately there should simply be one Act which dealt with incapable adults and mental health (Scottish Executive 2001c). This remains an aspiration rather than a reality

2.10.3.2 Reciprocity and rights issues

Millan, recognising user rights, promoted the concept of 'reciprocity', whereby if the state removes freedoms, it also has obligations “Such a right was strongly supported by many of the submissions we received, but is not formally recognised in the current [1984] Act” (Scottish Executive 2001c p5). Bell (2005) took up this theme when reviewing community care in New Zealand and argues that by redefining treatment to encompass social interventions, those in need should have a right to community services. However, despite using community orders since the early 1990s, Bell (2005) reports that there is still no legal obligation to provide community

services. Campbell et al (2006) reached similar conclusions looking across jurisdictions in Australasia and Europe, whereby community placements were increasing but community based services were clearly underfunded. As noted earlier Campbell and Davidson (2009) argue that compulsion without adequate, effective resources is unethical.

The Millan report (Scottish Executive 2001) set out ten principles (often called the Millan Principles), including ‘reciprocity’, to reflect the developing norms of human rights law in the new Act. In the final version the 2003 Act principles (s1-3) do promote equal rights and user-focused interventions but were framed differently and do not mention reciprocity. Several areas of the 2003 Act do, however, indirectly reflect reciprocity principles: statutory authorities are obliged to provide services (ss25-29), treatment is very broadly defined (s329) and ‘parental relations’ should not be adversely affected by intervention (s278). ‘Recorded matters’ allow conditions to be imposed, attempting to ensure essential aspects of care plans are delivered when granting CTOs (s64(4)(a)(ii)). Atkinson (2006) observed that the reciprocity principle was not as explicit as expected from this report, arguably underplaying the significance of the above sections in realising the concept.

2.10.3.3 Justification for detention and compulsion

Millan suggests that the grounds for detention under the 1984 Act, were somewhat circular, largely based on the criteria of 'necessity' and 'appropriateness', rather than a clearly articulated justification for detention (Scottish Executive 2001c). The following narrative reflects on the perceived evidence base for compulsion and also examines community compulsion, a key component of reforms enacted under the 2003 Act.

Bean (2001) looking more broadly at justification for detention under mental health law, drew similar conclusions to Millan in terms of the circularity of the arguments. He noted that in some countries detention may only be used where the patient lacks capacity to understand the need for treatment. Within the 2003 Act, the 'significantly impaired decision making' criteria for civil compulsion reflects this approach. Bracken and Thomas (2001) also regarded this as an essential criterion for compulsion. Bean (2001) however, argues that most reformers remain uninterested in justification for detention and compulsion and are more concerned with process issues. Atkinson (2006) asserts that detention in some US states can only be used where there is a danger to others, due, she suggests, to lack of proof of the efficacy of treatments. Bean identifies compulsory treatment as a poorly researched area: "rarely have we asked whether the use of these powers is effective, necessary or ... assisted treatment" (Bean 2001 p23). Bean argues that the dominance of Hoyer's (2000) 'thank you' theory in psychiatric decision-making generates complacency. This commonly held belief states that although unhappy about being detained, patients will later appreciate the benefits and thank the psychiatrist. Hiday et al (2002) suggests there are two poles to the debate around justification for compulsion in the USA. Civil rights campaigners seek to limit compulsion to those who pose dangers, whereas mental health professionals want minimal encumbrances to treating people. Bean (2001) asserts that the issues are complex and provided adequate safeguards are in place, coercion may lead to someone receiving much-needed treatment. Although the 2003 Act is arguably based on Hiday et al's assumption that people would want to be treated should they become ill and unable to consent, the least

restrictive principle in s1 does attempt to ensure that informal avenues are considered first.

Anticipating the expansion of community-based compulsion under pending legislative reforms, Canvin, Bartlett and Pinfold (2002) undertook what they claimed was the first significant study gathering qualitative data on users' perspectives of community compulsion. They argue that many studies have looked at compliance, community living or discharge planning and assessment, but none have examined service users' responses to compulsion in a truly analytical way. The research, adopting a narrative approach, reported on the experience of 20 people, subject to community compulsion under Supervised Discharge Orders (SDOs) and guardianship under the 1983 Act, across several English Health trusts. Despite the legislative and policy rhetoric of involvement and least restriction, all participants perceived a threat of hospitalisation if they failed to comply and adopted a fatalistic, disempowered, demeanour in relation to the orders. In many cases participants saw compliance as a means to an end, particularly keeping out of hospital and living independently. Some perceived use of compulsion as punishment: "I was a pest, a nuisance, they wanted to get rid of me, I was always in court, lots of prison (Carl)" (Canvin, Bartlett and Pinfold 2002 p363). Campbell and Davidson (2009) highlighted the subtle and at times hidden nature of compulsion, noting that there was little evidence for formal community compulsion, yet informal measures compromised the legal and human rights of patients.

Marland (1999 in Canvin, Bartlett and Pinfold [2002]) distinguishes between 'imposed compliance' whereby service users, subject to compulsion, respond with

resignation and fatalism and ‘chosen compliance’, which is achieved by providing information, and can facilitate agreement with service users. It is acknowledged acceptance may result, because alternatives are seen as unpalatable. A third category, ‘active compliance’ allows service users much greater control, though it is unclear whether this actually applied to anyone in the study. There is no explicit acknowledgement that the ‘imposed’ or perhaps even ‘chosen’ compliance models will only be imposed where someone meets the criteria for detention or compulsion. It is unlikely, where there is a high level of co-operation as in ‘active’ compliance, that formal measures would be used. It is also notable that both SDOs and Guardianship required patient consent, which Canvin, Bartlett and Pinfold (2002) acknowledge creates potential difficulties in applying their findings elsewhere. Similar measures in the Scottish legal framework do not require patient consent.

Issues of justification, enforcement and necessity relating to community based compulsion are evidently complex and it is debatable whether measures proposed and enacted under the 2003 Act address these in any meaningful way. There is nevertheless a clear legal process which allows patients to appeal, a safeguard not evident in some of the systems described above. With regard to justification for detention there is little added to the 1984 Act provisions, other than the need to justify these at Mental Health Tribunals, which does at least provide accountability and a means for service users to participate.

2.10.3.4 Amendments to the 1984 Act

Millan noted that there was little case law to guide interpretation of the 1984 Act, except where courts had become involved in disputes over personality disorder and ‘treatability’ (Scottish Executive 2001c). The inquiry which followed Noel Ruddle’s

release from the high-secure State Hospital in 1999 reviewed this and other similar high profile cases (Scottish Executive 2000b). The court agreed that he did not have a treatable mental illness, despite the undisputed facts that he had a personality disorder and had, in 1991, shot his neighbour with a Kalashnikov rifle. The Mental Health (Public Safety and Appeals) (Scotland) Act 1999, was enacted speedily as a direct result. This allowed the continued detention of patients subject to restriction orders, if a risk of serious harm to the public was proven, even where the need for medical treatment was not evidenced. This Act also amended the 1984 Act to include personality disorder within the definition of mental disorder. The 2003 Act retained this amendment and also broadened the definition of treatment (s329) to include nursing care and other less 'medical' treatments.

Community Care Orders (CCOs) were inserted into the 1984 Act in Scotland, through the UK-wide Mental Health (Patients in the Community) Act 1995, as a response to community care tragedies such as the Christopher Clunis case in 1994. These were widely seen as ineffective in achieving the objective of successful community treatment (Reith 1998). Millan noted that only 13 orders were imposed in Scotland in 1999/2000, suggesting this was due to cumbersome processes and lack of sanctions for non-compliance (Scottish Executive 2001c). This Act also imposed a maximum period of one year for 'leave of absence' from hospital. A survey of 275 psychiatrists revealed that 78% rejected limitations on leave of absence and 86% rejected CCOs (Atkinson et al 2002). Although caution was urged as views varied between different ages and specialisms of participants, these measures were clearly not well supported. Anecdotally it was reported that patients who were approaching the twelve month leave of absence limit, were being readmitted to hospital over-night

then discharged for a further year the next day, as the 12-month limit counted from each hospital admission. Atkinson et al (1997) refer to ‘informal’ concerns about this practice, found during a related survey of 266 patients in Scotland.

With rather more success the Care Programme Approach (CPA) (SWSG 1996) was introduced across mainland UK in 1996, though it had existed in a less formalised way since 1993 (Warner 2005). Millan made clear that long-term compulsory interventions should be based on a clear plan of care, citing CPA processes as an appropriate model for this purpose (Scottish Executive 2001c). The CPA introduced a more structured care management based approach to those who presented the greatest risks to themselves or others. Key to this process was the participation of the patient. Guidance for the CPA was slightly different in Scotland and its use has fluctuated. A large scale study undertaken in Dundee (Dick et al 2003), reported that the CPA was well used: of 1457 patients on the caseload of community psychiatric services, 112 were on the CPA. However, within the 43 cases examined, paper files were seen as disorganised and cumbersome, the system seemed to be poorly resourced and risk neither appeared to be formally assessed nor clearly recorded. The report concluded that the CPAs effectiveness was questionable and proposed use of a standardised risk tool to better quantify and record risk.

A UK-wide literature review on the CPA was conducted by the Sainsbury Centre for Mental Health (Warner 2005), as part of a wider review focusing on patients subject to compulsory hospital admission more than once in the previous three years. Whilst the report identified a patchy response to implementation it was acknowledged local flexibility might be intentional and desirable. Although focused on the English

experience, CPA principles and procedures are similar across the UK. The Warner review asserts that service users report better outcomes and greater satisfaction with services when involved in their care planning and risk management processes. MWC reports examined earlier in this Chapter frequently highlight failure to use CPA procedures in Scotland. The (frequently) revised Memorandum of Procedure for Restricted Patients, hereafter referred to as the 'MOP', (Scottish Government 2010e) sets out a clear requirement to use the CPA with mental disordered offenders who pose active risks to others.

2.10.3.5 Other concerns raised by the Millan Committee

Millan identified many cases where people did not receive treatment until their mental health had deteriorated so far as to become a crisis (Scottish Executive 2001c), also reflected in several MWC inquiry reports (MWC 2014h, 2014e, 2010c). This 'de facto' detention was also identified as a problem by Millan, referring to patients who are not formally detained, but fear that they might be should they try to leave or who do not understand their rights to leave or refuse treatment. The Bournewood judgement (ECHR 720 2004), discussed in detail in paragraph 2.11.1, was based on concern about these issues.

Many respondents to the Millan Committee expressed disquiet with the power invested in nearest relatives, as defined in the 1984 Act (s53). These powers were exercised even where the patient objected to relatives' involvement due to previous abuse, neglect or simply conflictual relationships (Scottish Executive 2001c). Named person procedures discussed more fully in the next section addressed this issue to some extent.

The report also discussed sexual offences and mental disorder, noting that remedial measures under the 1984 Act were perhaps unduly restrictive. The 2003 Act made significant amendments updating the conditions in which non-consensual sexual acts are deemed to have taken place (s311). Ongoing concern around these issues was highlighted in one MWC inquiry (MWC 2008b) later followed by guidance (MWC 2012d) which went some way to offering advice to professionals on this complex area.

2.10.3.6 Criminal procedures and mental health law

The interface between criminal justice and mental health systems was examined in depth by Millan (Scottish Executive 2001c). Atkinson (2006) argues that whilst in England and Wales, debate raged about dealing with the risk of violent crime associated with mental disorder, politicians and legislators in Scotland played a clever political card. The 2003 Act and the interface with the Criminal Procedures (Scotland) Act 1995 (CPSA) were to remain largely unchanged, whilst violent offenders would be dealt with by means of a new Criminal Justice Bill. Attempts to anticipate offending behaviour by people with personality disorder inflamed opinion in England and Wales, while the Scottish parliament quietly achieved the aforementioned 1999 amendment almost unopposed, likewise Parts 8 -13 of the 2003 Act concerned with offenders (Atkinson 2006).

One difference between civil and criminal aspects of the 2003 Act is that Compulsion Orders can enforce treatment and detention for those with mental disorder, who have committed offences, even where their decision-making is not assessed as impaired. Bean (2001) explores this as a more general ethical issue for mental health law. He was uncomfortable with parallels drawn between the two types of law

namely ‘therapeutic’ (where the rules provide discretion and are purposive in nature) and ‘formal’ law (which are rules and procedure based and have an underlying objective of justice) arguing that these laws have quite different purposes. He argues that equality cannot exist where a law is based on medical decisions, noting that mental health law is often deliberately vague and that unlike criminal law there are no consequences for those who erroneously exercise functions under the law. Bean (2001) further highlights the potential for lack of accountability, where someone with mental disorder who should be held to account under criminal law, is instead diverted from prosecution. Paradoxically he writes, some may be incarcerated under mental health law for a disproportionate time for relatively minor crimes, where someone without mental disorder might not even receive a custodial sentence.

Buchanan (2000) considering the issue of responsibility from an Anglo-American legal perspective, points out that the mental state of the offender at the time should be seen, legally, as a ‘mitigating’ factor and may therefore require a different sentencing outcome. However, he notes that courts hold considerable discretionary power and will not always hear psychiatric evidence. He suggests that judges are anxious about where the need to consider psychiatric factors might end, though expresses surprise that psychiatric factors are not advanced more often. He notes “those with phobias relating to confinement ... will be more distressed by a prison environment. The mentally handicapped may be subject to verbal and physical abuse, and the odd ideas and unusual behaviour associated with schizophrenia may render them similarly vulnerable” (Buchanan 2000 p9). This is an important matter, recognised in the Millan Report (Scottish Executive 2001c), but about which there is

disagreement amongst professionals and for that matter the public, partly dependent on the nature of the offence.

These differences of opinion were highlighted in a detailed study on Garry David (Greig 2002). Incarcerated in Australia in 1982 for two violent offences, psychiatrists opined that David was so dangerous he should never be released. Historically, in Australia, law breakers were sometimes seen as heroes, Greig argues, but when 'madness' is associated with 'badness' a sense of fear and irrationality is engendered. David had a personality disorder and was infamous for his defiant stance against incarceration and the graphic nature of his self-mutilation, which eventually led to his death in 1993. This was not an isolated issue. Greig (2002) states that 4% of prisoners in Victoria state were diagnosed with personality disorder and that in 1982, at the time of David's incarceration, 115 incidents of self-mutilation or attempted suicide were related to 90 inmates. As with Noel Ruddle, the state was convinced of David's dangerousness, and the link with personality disorder, and consequently changed the law to ensure his incarceration beyond his stated release date. Greig argues that the law looked beyond the "factual elements of the offence...it sought an understanding of the personality and motivation of the offender...thereby...encouraging particular categories of dangerous persons to be decided on the basis of medical opinion" (Greig 2002 p16).

In more general terms, Greig (2002) highlighted the double stigma attached to forensic patients who somehow became a separate category of the mentally ill. This concept of 'double stigma' was referred to by Campbell, Healy and Brophy (2006) in relation to the detrimental effect of social exclusion and mental illness, though in fact

mentally disordered offenders may also experience exclusion, subjecting them to even greater potential for stigma. Greig (2002) highlights concerns in literature about the shift of responsibility for incarceration to psychiatrists. She also echoed Bean's (2001) thoughts about compromising basic human rights, by replacing time limited punishment with a more open-ended 'therapeutic response'. The David case has ongoing reverberations for the Australian legal and psychiatric systems and similar ethical debates continue, in relation to the incarceration and treatment of those with intractable mental illness and personality disorders, who pose risk to others. Perhaps reflecting continued risk aversion, in 2000, Victoria had one of the highest rates of community-based CTOs in the world: 55 per 100k of population compared to 1.7 per 100k in Ontario (Campbell et al 2006).

Prins (1995) provided a definitive text on the link between offending, mental illness and deviance which, although dated in terms of legislation, clearly sets out the dilemmas and arguments around the 'criminal' versus 'patient' dynamic. At the root of this assessment is the key issue of whether the individual is capable of taking personal responsibility. This debate underpins thinking in the Millan Report (Scottish Executive 2001c) about intervening with people who lack insight into their behaviour, but are nevertheless affected by serious mental illness. Millan notes that trying to achieve a balance between civil and criminal responses, whether from a medical or legal perspective, is very challenging, arguing that his background as a probation officer, working with mentally disordered offenders enabled him to adopt a more social perspective. From a legal perspective on responsibility, he discusses wide-ranging examples, where problems range from sexual assault and fire-raising to 'nuisance' kind of behaviours.

Prins (1995) notes that the law rarely views substance misuse as a reason for diminished responsibility, rather ‘inherent’ conditions which may affect an individual’s liability for their actions. He outlines the disposals in law for mentally disordered offenders and like Bean (2001) and Millan (Scottish Executive 2001c) identifies anomalies in the way that cases are dealt with. Drawing parallels with wider community care services for the mentally ill, Prins calls for better multi-agency collaboration in a context of “haphazard and sometimes irrational approaches ... bedevilled as they have been (and still are) by underfunding and lack of co-ordination” (Prins 1995, p44).

In Scotland ‘insanity’ as a defence is largely a matter of common law, established through case law over decades and rooted in Commentaries on the Laws of Scotland (Hume 1819, cited in SLC 2003). Fitness for trial and the treatment of persons considered insane at the time of committing the offence are dealt with in the CPSA. Despite recommendations for extensive reform of these measures (SLC 2003) they remain largely unchanged.

Following the Noel Ruddle case, The Scottish Office commissioned the MacLean report on Serious, Violent and Sexual Offenders (Scottish Executive, 2001a) to examine issues surrounding dangerous offenders. This report provides extensive commentary on risk management and helped establish the Scottish Risk Management Authority (RMA). Crichton and Darjee (2007) argue this led to considerably increased emphasis on risk assessment throughout social care and influenced the drafting of provisions for mentally disordered offenders in the 2003

Act. Darjee (2003) particularly welcomed the changes whereby the RMA allowed compulsory hospitalisation to be effectively sidestepped in favour of prison-based sentences for the most serious offenders, except where the mental disorder is clearly susceptible to treatment. Like Atkinson (2006), Crichton and Darjee (2007) identified the problem with the MHA 2007, as attempting to use mental health law to enhance public protection, whereas the 2003 Act clearly focused on care and treatment and thus violent offenders continued to be subject to imprisonment. The 2003 Act reinforced safeguards which allow prisoners with acute mental health problems to be treated in psychiatric hospitals and then returned to prison. Crichton and Darjee (2007) argue that the problem of violence and mental disorder in society is much more about controlling violent behaviour than it is about mental disorder and, linked to themes discussed earlier (Prins 1995), suggest that attempts by legislators to pathologise violent behaviour simply place obstacles in the way of tackling it.

2.10.3.7 Mental Health Tribunals

The Millan report (Scottish Executive 2001c) sought to legislate for justification, fairness and involvement by creating the Mental Health Tribunal for Scotland (MHTS). Unlike review-based tribunals elsewhere, MHTS adjudicates on all applications and reviews relating to long-term compulsion, whether civil or criminal in origin, and determine some appeals. The MHTS president has sought to prioritise and promote the concept of therapeutic jurisprudence in tribunal processes (Morrow 2012), the earlier noted ‘discretionary’ and ‘purposive’ approach (Bean 2001), which emphasises ‘inquisitorial’ rather than ‘adversarial’ responses. Campbell and Davidson’s (2009) review of debates on ethics of coercion found that, where compulsion was seen to be undertaken in a professional, inclusive and humane manner the outcomes were better for service users. Wexler (2000) referred to

therapeutic jurisprudence as managing the impact on the psychological well-being of those subject to law and enabling the law to deliver therapeutic interventions. This concept originally arose from trying to resolve problems with mental health law: “it looked at the way in which a system designed to help people recover or achieve mental health often backfires and causes just the opposite” (Wexler 2000, p128). How far the new legislative framework achieves such therapeutic objectives would be a good indicator of whether it is achieving wider positive aspirations or if like other mental health systems, it too backfires.

2.10.3.8 Learning disability

The Scottish Executive (2001d) accepted most of Millan’s recommendation (Scottish Executive 2001c) including that learning disability should be covered by separate legislation, albeit this has not been achieved, probably because few people with learning disability become subject to the legislation. Implementing legislative proposals for ‘vulnerable adults’ (SLC 1997) was acknowledged to be a continuing priority (Scottish Executive 2001b) particularly as it might address legal issues for people with learning disabilities that were not covered elsewhere.

2.10.3.9 Summary

The 2003 Act incorporated wide-ranging perspectives and attempted to square what were viewed as ‘unsquareable’ circles in England and Wales, juxtaposing public safety and new respect for civil liberties. Participation, a key theme of the 2003 Act, inevitably poses dilemmas for those attempting to administer it, seeking to involve users and carers or close relatives at every stage of the process. The requirement to utilise evidence, including detailed risk assessment, to convince tribunals that the grounds for compulsion are met, seems to be a strength, likewise measures to compel authorities to properly fund community care arrangements. Assessing

whether the 2003 Act succeeds in achieving these aims provides wide opportunities and challenges for future research.

2.10.4 Adult protection

The introduction of the 2007 Act took place in the context of discussions around the emerging 2000 and 2003 Acts. The 2000 and 2003 Acts adopted new approaches to care and treatment for those with mental disorder or who lacked capacity. Proposals contained in the Report on Vulnerable Adults (SLC 1997), sought to legislate for those considered ‘vulnerable’ for some other reason (Scottish Government 2011a). However, as Patrick and Smith (2009) note, lobby groups exerted considerable pressure to change the title and limit powers, resulting in the somewhat truncated Adult Support and Protection (Scotland) Act 2007, which replaced the term ‘vulnerable’ by ‘adult at risk of harm’. Although the first Act of the legal framework drafted, it was the last enacted, partly reflecting doubts about what groups this Act targeted.

Recommendation 11 of the Borders Inquiry specifically urged revival of this Bill (SWSI 2004). This Inquiry was undertaken following the hospital admission of a woman with learning disability who had been badly injured, by her carers. On closer investigation several individuals in similar situations were identified. In this case the carer, a convicted offender had, along with associates, systematically abused Ms X. Despite key agencies having knowledge of her situation, reportedly nothing was done to protect her from harm. This was despite numerous recorded reports of concern, planning meetings and assessments. Poor case recording, risk assessment, communication and disagreement between agencies were all cited as issues which needed to be addressed (SWSI 2004). Twenty-eight recommendations

were made and later reviewed, when significant improvements in many areas were reported (Scottish Executive 2005c). This report led to the immediate instigation of vulnerable adult processes across Scotland, prior to the 2007 Act.

The Scottish Government commissioned Hogg and Johnson (2009), to examine these processes across Scotland and report on readiness for implementation of the 2007 Act. This substantial study, spanned four local authority areas, participants included a wide range of professionals, involved in 23 cases which were closely scrutinised. How or when the cases were identified is not clear and no service users or carers were interviewed. The emphasis of the study was on the effectiveness of interagency working and adult protection processes. The researchers sought to set a base line, before implementation, against which future research on the Act could be compared. Broadly the report concluded that, whilst good practice was evident, collaboration lacked effectiveness, agency thresholds differed substantially, processes were either absent or not adhered to and risk management lacked transparency. Many social work participants reportedly preferred care management approaches and actively avoided adult protection processes. Frequently case conferences were poorly minuted and failed to address key issues or put in place adequate protection plans. Key professionals (particularly advocates) and the adults themselves were often not present and attendance of perpetrators was inconsistent and poorly managed. Given that the data (undated) presumably significantly post-dates the Ms X inquiry (SWSI 2004) there was little to reassure Government that the issues raised in the inquiry had been addressed by these new processes.

The report (Hogg and Johnson 2009) makes 25 wide-ranging recommendations about risk management, training, development of inter-agency processes and preserving the autonomy of the individual subject to measures. Recommendation Six identifies the need to address problems arising from assessors rating the risk of harm according to perceptions about the status of the person making the allegation, which interestingly mirrors an earlier noted observation about psychiatrists by Reith (1998).

Whilst neither this document nor any Government response to it is readily available, on the Government's website, some of the recommendations about formal risk assessment processes and joint training were addressed in the implementation phase of the 2007 Act. Hogg and May (2011) also produced self-evaluation materials for local partnerships, at the Government's request, but no audit exists of how widely these have been used.

Finally enacted in October 2008, it was thought unlikely the 2007 Act would be used very much (MacKay et al 2011). Measures included allowing local authorities to enter premises to assess (including medical assessment), removal of an adult at risk of harm and banning perpetrators of harm from the vicinity of the victim. However, medical examinations or interviews cannot be enforced and other powers can only be enforced if the adult is demonstrably under undue pressure to withhold consent. Any link between incapacity and susceptibility to undue pressure is not clarified and oddly the 2007 Act only uses the word capacity with reference to amending other Acts.

2.11 The operation of the current Scottish legislative framework

At the beginning of this review of literature the lack of detailed evaluation or even commentary on the current legislative framework was highlighted. That is not to say that none exists, but much is concerned with providing guidance on use of the law rather than analysis of how it operates. There are some exceptions to this and since this thesis was commenced more critical analysis became available and is included. Studies presented in this section are grouped under the relevant Act, though some focusing on the interface are grouped together to help inform the debate about the coherence of this framework.

2.11.1 Adults with Incapacity (Scotland) Act 2000

Enacted incrementally from 2001, the 2000 Act set out a framework to provide care and support to adults incapable of protecting their own welfare or financial situation and to deal with medical consent issues. The Act placed protective obligations on local authorities, created the OPG to oversee financial interventions, and redefined and removed guardianship from the 1984 Act.

The most comprehensive study examining the 2000 Act is ‘Learning from Experience’ (Killeen et al, 2004), commissioned by the Scottish Executive. This report took over two years to complete and involved gathering quantitative data on the use of the Act, utilising qualitative approaches to gather stakeholders’ views and encouraging the development of networks of interest to contribute views. Three key stakeholder groups were identified: user/carer groups, agencies with ‘operational responsibilities’ and those with ‘duties’ under the Act. Separating out responsibilities from duties makes a rather odd distinction as health and social work staff exercise both. It was intended that the report should monitor use of the Act, undertake

research into its operation and identify issues arising. Limited quantitative data was presented which demonstrated use of the Act so far, but the findings from qualitative research, involving participants from several stakeholder groups, was of greater interest. The qualitative elements focused on Power of Attorney (Part 2), Access to Funds (Part 3) and Guardianship and Intervention Orders (Part 6). This report (Killeen et al 2004) provides a useful basis for wider discussion around the developing use of the Act.

2.11.1.1 Powers of Attorney (Part 2)

The user perspective in relation to Part 2 was limited in this paper as no-one who exercised, or was subject to, powers was interviewed, though input from various professionals and interest groups was included and some feedback was gained from individuals who had granted powers. Participants believed the powers themselves were potentially useful, though the processes were complex and public awareness was low. Little criticism was levelled at attorney arrangements at this time, but later concerns arose over the abuse of powers by attorneys (MWC 2012h). Debate over the relative authority of attorneys and guardians, discussed later in this section when considering Part 6 of the Act, was also not apparent at the time.

2.11.1.2 Access to Funds (Part 3)

Even at the stage of the Killeen et al report (2004), Part 3 arrangements were considered difficult to implement and concerns were expressed about processes relating to representation for service users and relatives. Reforms were eventually realised under the 2007 Act, following which Part 3 applications granted rose from 200 to 400 annually (OPG 2014), but as yet there is little research into these revised arrangements. The local authority code of practice (Scottish Government 2008a) asserts that use of Part 3 is a less restrictive alternative to financial guardianship.

2.11.1.3 Medical treatment (Part 5)

Part 5 primarily involves health staff but it is important for those discharging local authority functions to be aware of how it operates. For example, MHOs need to consider possible intervention under Part 5 when reporting on more restrictive measures under Part 6. Reforms introduced under Part 5 in October 2003 were contentious and several studies looked at the effectiveness of these measures, at a surprisingly early stage, given that it was the last Part to be introduced.

The Scottish Government commissioned a qualitative study into the use of Part 5 (Davidson et al 2004) very soon after its implementation. The study involved a range of professionals and carers utilising interviews and questionnaires, across four areas in Scotland. The view was generally positive with, unsurprisingly, health professionals being more likely to use Part 5 than local authorities, given that the powers are exclusive to health professionals. Although practitioners claimed to have received good training, awareness of processes was limited and several reported an increase in workload and frustration that other professionals did not understand their responsibilities.

With remarkable speed, a report was published analysing the responses (Drinkwater et al 2004) which concluded that some aspects of the timescales should be relaxed and, more importantly, that the category of health professional who could issue certificates should be extended to include registered nurses, dentists and opticians. Emphasising the time lag from policy decision to legislative change, these relatively minor amendments to the Act were eventually realised four years later through s35 of the Smoking, Health and Social Care Act 2008.

In a study conducted in medical wards across a Glasgow teaching hospital, of 50 medical and nursing respondents to a questionnaire, none reported having had any formal training on the Act. Despite this 41% claimed to be confident in using the Act, 64% believed, incorrectly, that relatives could sign consent forms if a patient could not and many held erroneous beliefs about the powers or applicability of the Act (Ramsay 2005). There have been three versions of the Code of Practice in relation to Part 5 (Scottish Government 2010c)

As social work staff who act as Welfare Guardians routinely hold powers to consent to medical treatment, confusion amongst medical staff about their own duties will not assist social work in discharging such responsibilities. For example, advice is confused around whether Part 5 permits use of force to administer treatment. The Code of Practice (Scottish Government 2010c) cross-references guidance from the MWC and Care Inspectorate and is somewhat equivocal in its advice, suggesting guardianship or intervention orders may be required. A MWC good practice guide, The Right to Treat, (2011a) advises that a man with basal carcinoma should be compelled to accept treatment under Part 5, yet the later report on Ms R's case (MWC 2012g), supported the authority's decision not to enforce intervention under Part 5 to compel her to accept assessment and treatment for cervical cancer, from which she subsequently died in considerable pain. The Right to Treat (MWC 2011a) also seeks to clarify confusion over the right to administer covert medication, having first published guidance in 2006 (MWC 2006a)

2.11.1.4 Part 6 Guardianship and intervention orders

Killeen et al (2004) devote substantial space to reviewing Part 6 of the 2000 Act. Case studies were picked from three local authority areas, and semi-structured

interviews were conducted with all involved parties, including the adult and nearest relative. The focus was on process issues, outcomes and any interface with other legislation. The 13 cases cited reflected most service user groups, namely, older people, mental health, learning disability, brain injury and physical disability.

Killeen et al conceptualise incapacity as existing at three levels: global, partial and full, though what benefits a classification system might provide is unclear. 'Global' incapacity occurs when all five aspects mentioned in s1(6) are problematic, namely remembering, making, communicating, understanding or acting on decisions. However, someone may struggle with trivial decisions in all these areas, but nevertheless be quite sure they do not wish to be in a care home. My view is that 'global' incapacity would be more likely to occur when decision-making from the most trivial to the most significant level is problematic. However, the Act does not make such distinctions and besides which capacity is decision-specific, so such a classification system is contrary to the spirit of the Act.

These "levels" are linked with two alternative frameworks for linking risk, capacity and powers: the 'risk orientation' and 'decision-making orientation' models (Killeen et al 2004 p82 and Appendix 6). The risk framework is linked to local authority actions to manage risk and the decision-making model is linked to family interventions where adults are close to the 'global incapacity' level. However, local authorities cannot initiate powers of attorney under Part 2 (linked with the risk framework) and often are legally obliged to act where adults are significantly impaired, because it is necessary and no-one else is willing or able to act (s57(2). These frameworks are fairly simplistic, in that this system of substitute decision-making will also deal with risk and

vice-versa so there is considerable overlap between these apparently separate models. It is acknowledged that these models reflect findings from the research and are a clear attempt to understand an identified phenomenon, but the emphasis on this is somewhat overstated, given the limited sample at an early stage in implementation. Problems dealing with fluctuating capacity are clearly important and are acknowledged, but the implications are not explored in any detail (Killeen et al 2004).

Killeen et al (2004) concluded that some outcomes might already be achieved prior to a Part 6 order being granted, following on from informal respite arrangements or use of mental health law, and suggests that outcomes may be 'substantive' or 'procedural'. The former refers to issues related to accommodation, safety, quality of life, medical treatment, finance and accessing information and services. It is suggested that adults subject to Part 6 benefit in one or all of these areas, though lack of resources remained a problem, order or not. The report particularly highlights onerous demands on financial guardians. The limited discussion on 'procedural outcomes' anticipates a key issue in later debates. "Procedural outcomes" may "provide a formal legal basis for arrangements that may already exist" (Killeen et al 2004 p93). Tension between supporters of the need for a legal framework and those who think it unnecessary is highlighted. Killeen et al (2004) refer to the efforts by the Social Work Services Inspectorate (SWSI) to modify the thresholds for use of guardianship in 2003, less than two years after implementation.

Several Guardianship applications examined contained wide-ranging and sometimes un-necessary powers. Ward (2003) called these 'plenary' powers, which may be

appropriate where someone, uncertain of future needs, is assigning ‘anticipatory powers’ as in a Power of Attorney, but is much less so where the powers being sought are more ‘remedial’ and not ‘pre-authorised’ by the adult. Such plenary powers sought under guardianship would conflict with the least restriction principle (s1(3) the 2000 Act).

2.11.1.5 Developing perspectives on the use of Part 6: 13ZA and the Bournewood judgement

The main areas to be addressed, according to Killeen et al (2004), related to lack of common understanding of the Act and associated processes, the legalistic context of court applications, and importantly, who was responsible for interventions. It was suggested the Act is cumbersome and would benefit from some simplification. Problems accessing legal aid, representation and lack of emergency powers were also identified. The principles and the redefining of capacity were viewed as helpful, particularly the increasing acceptance that incapacity was no longer ‘all or nothing’, but based on decision-making and individual circumstances. The integration of incapacity law under one Act and enhanced ability to intervene were also welcomed. Although neither given great prominence, nor explicitly backed by evidence, Killeen et al (2004 p109) conclude that “broadly the Act is working and yielding benefits for adults with incapacity and for those who care for and about them”.

Some of Killeen et al’s (2004) proposals were eventually realised in amendments through the 2007 Act, but the time lag here is significant, emphasising that legislation is not the most flexible way of responding to complex and changing need. Some issues have not resulted in change, such as the Sheriff Court setting for Part 6 applications. One key finding which Government did accept was the apparent lack of clarity amongst local authorities when to ‘evoke’ (sic) the Act (Killeen et al 2004).

Guardianship was increasingly viewed as resource intensive due to application and monitoring arrangements. Several advice notes and letters from Government and the SWSI followed (cited in Patrick 2008), suggesting that common law powers such as 'duty of care', negotiorum gestio (the doctrine of necessity) and powers under s12 of the 1968 Act, might provide sufficient authority to allow local authorities to place adults who lacked capacity in care homes. The MWC produced two reports (MWC 2005, 2004) aimed to clarify these issues, but rather than providing clear guidance, these included yet more recommendations for debate and discussion around the complex issues involved. The eventual Government response was to insert S13ZA (hereafter 13ZA) into the Social Work (Scotland) 1968 Act, through s64 of the 2007 Act, rather than amend the 2000 Act. This rather innocuously section entitled "Power to help incapable adults benefit from social services etc", temporarily curtailed debate about alternative means of placing adults in care homes. This was enacted immediately the 2007 Act received Royal assent, clearly indicating the Government's wish to reduce the use of guardianship.

Highland Council had developed guidance for when guardianship should not be used, dispersed more widely alongside one Government letter, but it was later incorporated into the local authority code of practice (Scottish Government 2008a) to support use of 13ZA. Guidance clarifies that 13ZA authorises provision of services, including accommodation, to a 'compliant' adult, provided no-one with a legitimate interest objects and no 2000 Act application is underway. Various safeguards are suggested and considerable emphasis is placed on the need to avoid deprivation of liberty.

The Bournewood judgement (ECHR 720 2004) was increasingly cited as a benchmark against which to assess deprivation of liberty. This case concerned a young man with autism, who without legal authority was taken into hospital and prevented from leaving for several months. This was justified on the grounds of protection and treatment, but the family, whose contact with him was restricted, took legal action eventually reaching the ECtHR, which concluded he had been subject to a deprivation of liberty, breaching his rights under Article 5. This has resulted in amendments to law or guidance in mental health and incapacity law across the UK and beyond.

In Scotland an independent report citing MWC guidance, opposed a guardianship application by a relative in the Muldoon case (Sheriff Courts 2004), arguing that it was unnecessary to use Guardianship to keep the adult in a residential home as she was consenting to be there and all agreed it was in her interests. However, citing the Bournewood judgement (ECHR 720 2004), the Sheriff granted guardianship as she could not meaningfully consent to be there. Stevenson, Ryan and Anderson (2009) cite another decision by the same Sheriff in which he asserts that all informal care arrangements, for compliant but incapable adults should be reviewed to consider whether guardianship should be sought. In the JMR case (Scottish Courts 2013) the MHO argued that guardianship was unnecessarily restrictive and that 13ZA and a combination of lesser measures from the 2000 Act, alongside DWP appointeeship, could be used to manage JMR’s welfare and finance. The Sheriff disagreed and granted welfare and financial guardianship, arguing that this was the least restrictive measure available to meet the adult’s needs.

In the Donnet fatal accident inquiry (Scottish Courts 2007a) the service user, who had a learning disability and lived relatively independently in a hostel, refused medical treatment for ulcerative colitis and ultimately died as a result. The Sheriff was very critical of medical and social work input and insisted that Guardianship should have been sought. The Ms A inquiry (MWC 2008a) post-dated 13ZA, yet the MWC were very critical of the local authority for failing to use guardianship to underpin a protective community living arrangement, with which all including Ms A, were in agreement. Ms A like many others in her situation benefitted from intensive 'support', although there is certainly a fine line between this and undue restriction of liberty which needs to be authorised by law. Ironically in Ms A's situation protection from harm could only be achieved by keeping her in a, much more restrictive, locked or heavily supervised environment. These cases provide contradictory guidance to that connected with 13ZA.

Ward commented that 13ZA could only be used in "situations which are genuinely non-controversial, and where the adult is entirely compliant" (Ward 2007, no page number). He asserts that it would never be competent for a sheriff to refuse an application under Part 6 of the 2000 Act, on the basis that 13ZA could be used, since the application itself implies there is some disagreement. Anticipating the 2000 Act, Crichton (2000) provides an overview of common law provisions in Scotland and welcomes the move towards a more transparent, clear-cut system of defining and intervening in relation to incapacity, Given the opacity of systems under 13ZA, this measure could be viewed as a backward step. Despite intentions expressed in the introductory letter, no Government sponsored research has been commissioned into use of 13ZA and no data has been collected on its use, so the impact on local

authority guardianship applications is unknown. The MWC in their monitoring report from 2011/12 (MWC 2012f) note that local authority applications have levelled out over the last three to four years but that private applications continue to increase.

Alongside moves to reduce the use of guardianship the Scottish Government and the MWC commissioned Hilary Patrick (2008) to explore issues surrounding deprivation of liberty. Her report provides lengthy, complex and at times contradictory discussion about capacity and deprivation of liberty, making links to the basic principles of the 2000 Act, under themes of 'benefit' and 'autonomy'. This is closely examined over the next few pages because it raises important questions about use of the legislative framework, from the perspective of a prominent commentator and the regulator. Although commissioned to shed light on deprivation of liberty, to assist in implementing 13ZA, the report was more wide-ranging and challenged basic assumptions about powers under both the 2000 and 2003 Acts. For example, Patrick (2008) questions whether even guardianship provides sufficient authority to effectively 'detain' people in residential establishments. Somewhat contradictorily she later argues that 13ZA is sufficient legal authority to place people in locked units in care homes, as this may be more liberating than being trapped in one's own house unable to access the wider community.

The report includes a lengthy checklist to assist professionals to assess whether care arrangements constitute a deprivation of liberty. Patrick (2008) cites legal debate around 'competent' as opposed to 'incompetent' attempts to leave a care establishment. 'Incompetent' attempts are classed as 'uninformed' intentions to leave and thereby not a deprivation of liberty, if the adult is prevented from leaving. This

echoes Canvin, Bartlett and Pinfold (2002) ideas around classifying levels of compliance. Patrick (2008) later cites a ECtHR opinion which suggests decisions about deprivation of liberty need to be based on the individual merits of each case.

Patrick (2008) cites a case where an Italian court restricted a mafia suspect, forcing him to remain in a small village on an island, applying various restrictions including a night curfew, which was seen by the ECtHR as a 'deprivation of liberty'. Patrick (2008) asserts that even where someone has 'consented' to detention this may be insufficient to avoid accusations of undue deprivation of liberty. This supports the MWC view in the Ms A case, that deprivation of liberty occurred because she could not give informed consent to being accompanied when out in the community (MWC 2008a). Patrick (2008) cites court decisions, one related to dementia, suggesting that it would be acceptable to impose restrictions where the adult would 'benefit' and then cites contradictory legal opinions minimising the significance of such decisions. A Norwegian study (Sorgaard, 2007) found that a third of patients, whether voluntary or subject to compulsory measures, did not know their legal status. Sorgaard also demonstrated that many voluntary patients perceived themselves as having been coerced, where some formal patients had actually wanted to be admitted. It is suggested that legal status, and patients' knowledge of it, is not a good proxy for whether or not patients feel they have been coerced. Campbell and Davidson (2009) argue that feelings of having been coerced are ameliorated if the quality of relationship with those exercising powers is good.

Sorgaard (2007) is critical of the use of compulsory powers to secure resources or as a preventative measure should patients choose to leave. Principles underpinning

the Acts seek to address these issues through promoting equal access to support (s3, the 2003 Act) and least restrictive alternatives (s1(4), the 2000 Act) which effectively discourage preventative detention or compulsion or use of such processes to facilitate access to services.

The difference between keeping someone under lock and key, or managing risk to maximise personal freedoms, reflects the earlier discussion on the difference between ‘defensive’ and ‘defensible’ practice (Loxton, Shirran and Hothersall 2010; Titterton 2005) This also potentially reflects the earlier noted consequences of failures to transfer resources to the community following the closure of long-stay hospitals: not least ethical dilemmas in justifying the use of compulsion, which might be unnecessary if sufficient resources were available to properly support individuals (Knowles 2000).

Far from supporting reduction of cumbersome legislative processes as intended by the introduction of 13ZA, Patrick 2008 goes on to argue that vast numbers of people may be unlawfully detained in hospital and urges the MWC to look closely at the care arrangements for such patients, with reference to the 2003 Act. The report goes on to state that use of seclusion and restraint is very likely to require authorisation by detention, yet rather contradictorily suggests that use of a ‘locked door’ in a care home does not necessarily amount to a deprivation of liberty. The report acknowledges that very structured and restrictive environments are likely to amount to a deprivation of liberty, but fails to recognise that most people requiring admission to locked facilities do lack capacity to agree. Many nursing homes do operate a restrictive environment, particularly Elderly Mentally Infirm units, where residents

may additionally be observed and accompanied at all times when out of their rooms (Lynch 2014).

Even more controversially, Patrick (2008) contrasts the relative authority of public officials and private individuals exercising powers, suggesting that it may be illegal to use power of attorney to authorise deprivation of liberty. It is unlikely this view would be welcomed by individuals who have been encouraged by solicitors and care services to set up attorney arrangements, sometimes at considerable expense. The Code of Practice (Scottish Government 2011b) encouraging take up of power of attorney, refers to the importance of authorising the attorney to take difficult decisions, including those about care, where the granter's capacity is impaired. However, the MWC apparently subscribe to Patrick's view: "if the person who lacks capacity refuses to comply, the attorney would have to consider applying for guardianship. The power to enforce compliance only exists with a guardian, not an attorney" (MWC 2007b, p12). This is neither specified in the Act nor discussed in the codes of practice. Neither the MWC (2007b, 2005) nor Patrick (2008) acknowledge that the Sheriff has wide discretion under s3 of the 2000 Act, which could include making a direction to comply with the instruction of an Attorney, in the same way s70 can require someone to comply with the direction of a guardian.

Having suggested that guardianship, not power of attorney, is necessary to authorise deprivation of liberty, Patrick (2008) further confuses matters by asserting that even guardianship cannot truly enforce a care home placement and that the correct route would be the 2003 Act. This again seems potentially flawed in many respects. One measure (S66(e) the 2003 Act) under a community-based CTO can require a patient

to reside at a specified place and s303(c) of that Act allows for the patient to be returned to that place if they have absconded, however, what constitutes absconding is open to wide interpretation. Guardianship powers on the other hand can be much more specific and may authorise staff to prevent the person from leaving in the first place. Ongoing non-compliance with a CTO would usually result in bringing the patient into hospital, yet in many cases adults currently placed under guardianship may never have been in hospital, particularly younger adults with learning disability (Brown 2006; Williams 2006).

Arguably then Patrick's report (2008) does little to clarify and much to confuse the issues. In fact despite the apparent purpose of the report being to address issues relating to deprivation of liberty, key recommendations sought further guidance from the MWC and Government sponsors about the broader issues identified within the report.

The OPG, also eager for reform of the 2000 Act, published a paper arguing for a 'graded approach' to guardianship (OPG 2011). Three levels of application are suggested for finance and welfare powers, the first two to be granted by the OPG based on: consensus amongst all involved, lack of complexity and lower levels of risk. The more contentious or complex cases would still be authorised through Sheriff Courts. The paper asserts that court applications would be reduced by around 50%, however, the OPG holds little information on the detailed considerations which have led local authorities and indeed private individuals to apply for guardianship, so such claims need to be treated with extreme caution. Although very much a discussion document, some of the issues have been picked

up in the recent SLC report (SLC 2012), discussed below, which considers reforms to the whole Act. The OPG report does however, provide a useful summary of granted orders (OPG 2011) which highlights the inexorable rise in numbers of application for welfare and finance powers. In the last year reported (2010/11) there was a 17% increase in combined financial/welfare guardianships, a slight levelling out of 'welfare only' applications and a 15% decrease in financial applications. The discussion in the OPG report does not reflect the earlier noted shift from local authority to private applications (MWC 2012f).

The interesting and important message that comes across here, from the point of view of this thesis, is that from the outset there has been considerable disagreement and discontent around Part 6 measures, particularly guardianship, and despite extensive guidance through codes of practice, agreement cannot be reached on many basic issues. The plethora of government sponsored discussion documents and minor amendments still do not appear to have brought clarity to this area. Despite implementation of 13ZA, the Bournewood judgement (ECHR 720 2004), various inquiries and Sheriff Court decisions, Scottish local authorities remain in a difficult position as to whether or not to use guardianship. Stevenson, Ryan and Anderson (2009) in part, attribute variable use of the 2000 and 2003 Acts to these conflicting legal decisions and related advice given to local authorities.

2.11.1.6 Assessing capacity

Ongoing debate about assessing capacity highlighted lack of certainty around who could and should assess capacity and is a source of considerable, and more generalised, difficulty within the 2000 Act. The gatekeepers for measures under the Act, as assessors of capacity, are generally psychiatrists and GPs, yet primary

responsibility for welfare interventions sits with local authority. The Scottish Government recognised this dilemma and commissioned, Jan Killeen (author of the 2004 report) to produce guidance for professionals focussing on communication and assessment of capacity (Killeen 2008). She had, by this time been appointed as AWI National Practice Co-ordinator, tasked with helping health and social care staff deal with the complexities of the 2000 Act and to review progress on implementation.

The guidance encourages a thorough, systematic approach to interviews emphasising the importance of using aids and adaptations to facilitate communication, advice already proffered in the original local authority Code of Practice. Sample interview schedules provide some helpful ideas about establishing capacity and 'condition specific' advice is sporadically helpful, though might be seen as patronising, for example it is advised for people with Huntington's to "use touch to show that you care" (Killeen 2008 p22). The guidance recommends use of neuro-psychological or other specialist assessments, but does not explore why this might be necessary. Overall whilst this may be a helpful document for practitioners, it cannot address the key issue of responsibility for assessing capacity and does not make recommendations in this regard. The MCA 2005 in England and Wales allows professionals providing care or treatment to act, providing they have reasonable cause to believe a person lacks capacity to consent (s5). This allows urgent responses, which are lacking in the 2000 Act (Killeen et al 2004) and addresses short-term problems obtaining medical support. However, longer-term measures are authorised by the court in a similar way to Scottish legislation.

2.11.1.7 Reviewing the 2000 Act

Prompted by the MWC, Enable and a sub-committee of the law society itself, who all identified the need for reform, the SLC report (2012) reviewing the 2000 Act draws some interesting conclusions, largely focusing on welfare guardianship and the impact of the Bournewood judgement (ECHR 720 2004). These were based not just on the operation of the Act in Scotland, but also a global perspective. Several important themes emerge from this report, set out and discussed below.

Deprivation of liberty

The debate about deprivation of liberty is conducted around two axes: the 'objective criteria', whereby someone is either 'locked up' or their freedom to leave their place of detention (or residence) is otherwise restricted or the 'subjective criteria', whereby an individual does not, or cannot, consent to such restriction. The paper examines measures under the 2000 Act, alongside some commentary on 13ZA, and argues that to be compliant with the ECHR, in terms of deprivation of liberty, local authorities should consider Part 6 orders when arranging care for adults lacking capacity. This is a contradictory finding to the MWC and Government, given the already discussed efforts to encourage less formal means. The SLC report examines decisions around the Muldoon case (Scottish Courts 2004), Docherty (Scottish Courts 2005 in SLC, 2012) and RMcC (Scottish Courts 2009 in SLC, 2012) all of which support the idea that where a compliant adult is unable to consent to a restrictive regime (including residential care), then the appropriate measure is welfare guardianship. However, the SLC argue that before concluding a deprivation of liberty had occurred, no consideration was given to the nature of residential care provided, and suggests, like the Scottish Government, that these decisions are consequently flawed in

considering ECHR case law. Interestingly, the report only considers deprivation of liberty in the context of a care homes or hospitals as opposed to community settings. The SLC (2012) support Patrick (2008) in questioning whether guardianship or power of attorney can really authorise deprivation of liberty, adding weight to an already controversial question.

The report also examines guidance relating to deprivation of liberty measures inserted into the MCA 2005, which reflects the need for individualised considerations discussed earlier (Patrick 2008). Reviews by the CQC and others so far, suggest this amendment has not been effective in dealing with the issues (SLC 2012). From a global perspective the SLC identified substantial differences even within the European Union noting that most countries have appeal processes and a range of requirements which must be met before placing an adult in a restricted environment and that many of these countries have recently amended their laws in relation to incapacity (SLC 2012).

Issues around medical treatment

The SLC (2012) assert that the legal framework in England and Wales has dealt with the issue of detention for physical treatment, using mental health law to detain, but incapacity law to treat, potentially addressing difficult questions arising from the 2000 Act. The SLC paper does not address the earlier noted issue of enforced medical treatment, as in the Ms R case (MWC 2012c) so at this stage there are no proposals to review this important matter.

Justification for intervention

The SLC report (2012) discusses the purpose of interventions, echoing the earlier debate on justification for detention (Campbell, Healy and Brophy 2006; Bean 2001).

The SLC argues that the emphasis should be on the reasons for, and potential benefits of, enforced measures. Whilst on the one hand concluding that the provision to manage deprivation of liberty in Scotland is inadequate, on the other the MCA 2005 approach is not supported. Some rather complex ideas are presented involving use of proxies and official individualised statements when there may be a risk of undue deprivation of liberty.

Clarity is also sought over the relative powers of attorneys and guardians and indeed whether anyone could be empowered under a different statute. The report also raises the important question of which statute (the 2000 or 2003 Act) is appropriate to underpin hospital admission for adults who lack capacity. An earlier reference in the report to the approach in England and Wales whereby mental health law takes precedence over incapacity law may indicate the SLC's preference.

Previous SLC reports (1995, 1997) have launched the 2000 and 2007 Acts respectively, so this report may well mark an important milestone for legislative change in Scotland and leading to a new interpretation of the 2000 and 2003 Acts and the possible revocation of 13ZA. However, given the already noted pace of legislative change, this may take some time.

2.11.2 Mental Health (Care and Treatment) (Scotland) Act 2003

The Scottish Executive commissioned a literature review (Atkinson et al 2005) on mental health legislation to coincide with the introduction of the 2003 Act. The review drew some international comparisons, raised issues relating to compulsion and detention in particular, and examined recent empirically-based research. This provides a good framework for discussion on developing use of the 2003 Act.

2.11.2.1 Use of detention and compulsion

The following section looks at use of compulsion prior to the 2003 Act, at international perspectives on compulsion and reviews existing research directly related to the 2003 Act. This provides a useful overview of the issues arising for researchers and provides some indication of how the 2003 Act is working in comparison to previous legislation and other models in countries with similar mental health systems.

A significant increase in the use of detention in Scotland was noted between 1985 and 2003, broadly 50% more emergency detentions, doubling of short-term detention and a 200% increase in long-term detention. Even at this early stage wide variation in the use of guardianship, across local authorities, was highlighted (Atkinson et al 2005). The review also examined critiques of the English tribunal system, but given that Scottish tribunals were not yet in place no comparisons on effectiveness were advanced.

Some consideration is given to the differences between capacity (s1(6)(a) 2000 Act) and ‘significantly impaired decision making’ (a core criterion for compulsion under the 2003 Act). Atkinson et al (2005) highlight the importance of understanding the difference between ‘capacity’ and ‘competence’ and closely examine approaches to enhancing capacity, a prominent theme in the 2000 Act codes of practice.

Reference is made to Gordon’s study (2004) comparing the two Acts which advocates use of the 2000 Act where an adult is unable to consent, but is ‘compliant’, and use of the 2003 Act where there is active resistance. This has certainly not been borne out in practice, use of guardianship being the principal

means for enforcing care home placements and 2003 Act measures almost invariably underpinning detention in hospital (Patrick 2008).

Atkinson et al (2005) identify potential traps arising from community-based CTOs, arguing that assessing the impact of law, especially community-based compulsion, a key element of the 2003 Act, is notoriously difficult. She cites trials in the USA which are at best ambivalent. Kisely et al (2005) warn of the ethical dangers of attempting randomised control trials, citing studies in the USA. It is also pointed out that these of necessity excluded those who posed a risk of violence, often the very group who, as noted above, might be subject to such orders.

Hiday et al (2002), already mentioned in the context of justification for use of compulsion, also suggest research on community-based compulsion is lacking. They questioned whether there is any proof of the effectiveness of legal intervention, concluding that searching questions need to be asked about recovery time, reduction of symptoms and improved functioning, to provide a meaningful evaluation. Hiday et al (2002) undertook research into ‘perceptions’ of coercion, an issue already raised in the earlier discussion around ‘de facto’ detention or compulsion. The findings were similar to a paper by Campbell and Davidson (2009), which suggested that coercion, whether actual or perceived, tended to be counterproductive and that where treatment was provided in a humane, inclusive way, whether or not under legal statute, outcomes were likely to be better. Atkinson et al (2005) linked effectiveness to the availability of resources, again a commonly identified issue (Campbell 2009; Stevenson, Ryan and Anderson 2009). Atkinson et al (2005) acknowledge that where someone is acutely unwell, legal coercion may be required to ensure the

person remains in hospital to allow whatever treatment is available to happen, though provide little analysis of the many complex variables around enforcing treatment in the community.

Kisely et al (2005), mindful of the Scottish legislative framework, undertook a comparative study between Western Australia, which used community-based CTOs, and Nova Scotia, which did not. 196 cases in Western Australia were matched with similar controls in Nova Scotia to establish whether community-based orders reduced readmission rates. The authors acknowledge it is hard to have a true 'like for like' comparison, but argue that using stratified samples based on age, gender and diagnosis helps minimise confounding variables. The types of service provision were also similar in both states. Nova Scotia does not have 'leave of absence' type arrangements, thus there is no element of compulsion when a patient is discharged from hospital. The study found that readmission rates from community-based CTOs were in fact higher, but that these readmissions were for shorter periods. The writers view this finding as significant but acknowledge that it is not possible to establish whether it was compulsion, increased intensity of treatment or supervision that led to this, at least partially, positive, outcome for patients.

A study, based on MWC case records, by Brown et al (2012) examined casefiles of all 1872 persons subject to a CTO in Scotland on 8th August 2007. Of those, 499 were subject to community-based CTOs, most were male, two thirds reportedly posed risks to others, many had psychotic illness, many were on depot medication and social isolation was common. The researchers found little difference between the profiles of hospital and community based patients and little evidence of long-term

benefit for those on community orders. Given the documentary nature of the analysis these findings should be treated with caution, however, similar findings about the profile of people subject to compulsion and lack of evidence for community-based options were evidenced in studies elsewhere (Campbell et al 2006; Lawton-Smith 2006). Research into the use of Scottish legislation remains limited, beyond commentary from the regulators although quite detailed quantitative data is available about certain aspects of the 2000 and 2003 Acts.

An extensive literature review of suicide risk and protective factors across Scotland was undertaken by McLean et al (2008). The review notes that those with affective disorders were twice as likely as the wider population to be hospitalised and, unsurprisingly, that a decision to 'hospitalise' is an indicator of increased risk. Whilst Choose Life, part of a much wider mental health and suicide prevention strategy (Scottish Executive 2001d) is cited, oddly no mention is made of the Scottish legal framework,

Henderson et al (2004) conducted a single-blind, randomised control trial with 160 patients in England to establish whether the preparation of a crisis plan, with similar features to an Advance Statement (s275, 2003 Act), would reduce the use of admission and compulsion. They conclude that there was a reduction in compulsory admissions, but less difference in overall admissions and almost none in terms of 'bed days'. The trial did report greater patient satisfaction at being involved in care decisions, indicating that Advance Statements may, as intended, be useful to support patient representation (Scottish Executive 2001c).

Lawton-Smith (2006), sponsored by the King's Fund, undertook a study, reviewing community-based orders in Scotland, six months after implementation, seeking insights to inform the developing mental health law agenda in England and Wales. Lawton-Smith asserts that it was not straightforward to gather data relating to use of the Act. Largely quantitative in nature, the analysis was based on a literature review, semi-structured interviews with 12 participants and a questionnaire for another four, all professionals involved with administering the Act. Approximately 160 orders were identified, mainly patients over 24, suggesting, according to Lawton-Smith (2006), that these orders were targeting the 'revolving door' patients. Interviewees suggested community-based orders were being used for those with a lengthy history of non-compliance with treatment and poor engagement with services: most either transferred from existing orders or followed on from hospital-based orders. The report concludes that whilst there is no evidence that community-based orders are being misused, there are concerns that a two-tier system will result, whereby those subject to compulsion attract more resources. No empirical evidence for this is advanced, but it reflects similar fears identified by Campbell, Healy and Brophy (2006), In an oblique critique of the Scottish system, lessons for England and Wales included the need for adequate resourcing, effective data collection and avoidance of a two-tier system (Lawton-Smith 2006).

Atkinson et al (2005) refer to the need for the legislation to help resolve difficult issues around the interface between mental disorder and offending, particularly for women, who it is stated have been poorly served by forensic services. Interestingly included under the heading 'minority groups', other aspects affecting women are also considered: including post–natal depression and child care. No figures are offered,

but an ISD report (2011) on UK Mental Health Hospital activity, demonstrates male and female admissions were almost identical at just over 10,000. Atkinson et al (2005) asserts that a range of groups from children to minority ethnic communities have been poorly served by mental health law and services and suggests that the new legislative framework is better placed to deal with the individualised issues for these groups. Atkinson notes that the 2003 Act has been welcomed (echoing Lawton-Smith 2006) but identifies significant issues for staffing and workforce development, particularly increased workload for MHOs and psychiatrists.

2.11.2.2 Developing practice around the introduction of Named Persons

Despite investing considerable resources to review the legislation (Scottish Executive 2001c), and a clear commitment to further research, as evidenced by Atkinson et al (2005), the Scottish Government has subsequently sponsored little research into the 2003 Act. There were however, two useful studies one into named persons (Dawson et al 2009b) and the other, a user-led study on early implementation of the Act (Dawson et al 2009a), reviewed later in this section on the 2003 Act. Berzins and Atkinson also undertook research into named persons, producing two reports, one reflecting views of stakeholders (2009) and the other from the perspective of MHOs and 'policy influencers' (2010).

Dawson et al (2009b) sought to establish how the named person role fitted with other forms of patient representation. Of 43 participants, most (75%) were MHOs or MHTS members and seven were named persons, of whom only two had direct experience of tribunals. Lack of response from patients, psychiatrists and 'default' named persons (usually the nearest relative (s254) appointed in the absence of nomination by the patient), all serve to undermine this study's validity. The report highlights

difficulties in accessing quantitative data, so the results are based on information provided by MHTS, supplemented by MWC data. There is undoubtedly a problem in monitoring use of the Act in areas such as this, but the approach to data gathering here seems limiting. The researchers record a hope for more reliable data from 2007, though in 2014 there are still no readily accessible statistics about named persons. Given the acknowledged uncertainty about the data, the report seems to unduly dwell on statistical information. Some attempt is made at a longitudinal analysis examining the pattern of representation over time, but the reliability of conclusions is again undermined by poor access to statistics. Berzin and Atkinson (2010, 2009), drew similar conclusions, from a similarly limited sample. Bearing in mind these notes of caution the findings of these reports are discussed briefly below.

Dawson et al (2009b) report that named person arrangements were welcomed and viewed as a clear improvement on nearest relative arrangements under the 1984 Act, highlighting the requirement to involve nearest relatives even where there was an abusive relationship. Although in broad agreement that this new flexibility improves patient choice, Berzins and Atkinson (2010) identified one drawback, possibly an unintended consequence, namely that the patient has no power to block the provision of information, as there was for the nearest relative (s110(4) of the 1984 Act). MHOs were nevertheless obliged under s19(5) of that Act to consult with the nearest relative when applying for an order, regardless of the patient's view.

Dawson et al (2009b) identify apparent weaknesses in the processes. They note that a patient may not have a relative who can act, the named person receives all papers in relation to activity under the Act, the right to not have a named person is not

sufficiently clear and that, as with Advance Statements, there is no central register. Named persons seemed more involved in the initial stages rather than at the review stage of orders. All these issues were picked up in responses to the wider McManus Review of the 2003 Act (Scottish Government 2009).

Nomination processes for named persons

Nomination processes for named persons came in for particular criticism whereby Dawson et al (2009b) suggest, without providing evidence, that MHOs, may be pressurised by tribunals to force people to have a named person. It is reported that 31% were nominated by the patient up to January 2008, thus as many as 69% were likely to be 'default' named persons. Service users can legally 'denominate' named persons but this reportedly rarely happens. Although acknowledging this may be because they are happy with the default arrangement, this is attributed to the belief that patients are too ill to choose. This is not necessarily the case as a patient may well be able to make a 'rational' choice about a nomination even if in other respects their decision-making is impaired. The wording of the Act simply requires that the patient 'understand the effects of nominating' (s250(2)(c)(i) 2003 Act). This sort of debate, similarly lacking empirical evidence, is also advanced in Berzin and Atkinson (2009, 2010) where concerns are reported about inappropriate persons being treated as default named person. Although 35% of the 20 services users interviewed would nominate a friend rather than a relative, partly seen as a way to relieve stresses for relatives, only one actually had a named person (Berzin and Atkinson 2009). Stakeholders suggest that no one wishes to consider nominating until the point of detention (Berzins and Atkinson 2010). Stakeholders were reported to have serious concerns over default arrangements, in particularly that it should not be compulsory to have a named person overlooking the facility to 'denominate' or bar the

appointment of named persons. Consequently, there is an erroneous premise for radical recommendations to removal the default named person processes altogether or to limit their access to information, potentially excluding them from meaningful participation. In the original consultation processes for the 2003 Act there was no proposal to withdraw the nearest relative whose independent role in supporting the patient was valued.

Role of the named person

Mixed views expressed around named persons having inappropriate access to information were discussed in all three studies, MHOs being less concerned than others (Berzins and Atkinson 2010). Dawson et al (2009b), seem unclear whether named persons are a party to proceedings, but they clearly are (S1 MHTS (Practice and Procedure) (No.2) Rules 2005), so to exclude named persons or limit information would be legally complex.

All three studies highlight concerns about the ability of named persons to participate in the process. For a few getting time off work was problematic but more commonly, particularly emphasised within the stakeholder group, access to information, advice and support was lacking (Berzins and Atkinson 2010). Campbell (2008) undertook a UK-wide study of the involvement of stakeholders in tribunal processes and found, similarly, that carers had difficulty accessing information and legal advice. Berzins and Atkinson (2010) reported MHO concerns about potential conflict of interest for them in supporting named persons, so accepted that the MHO role should be restricted to information-giving, but offer no suggestions as to who else might provide support.

Dawson et al (2009b) identified potentially valuable contributions of the named person including long-term support for the patient, providing context for the tribunal in decision-making and advocating for the patient, for example in relation to use of recorded matters. Interestingly no participants reported a negative effect of the role on the relationship with the service user and one service user commented that it helped re-establish a long damaged relationship. Very brief reference is made to the benefit of a named person for minority groups. Berzins and Atkinson's study of user and carer views (2009) reported negative feelings from several service users about family relationships, a few referring to being infantilised by family. Few participants displayed much understanding of the independent nature of the named person role, most viewing this as another form of advocacy.

Other forms of representation

Dawson et al's (2009b) paper purports to address the interaction between named person and other forms of patient representation which include advocate, lawyer, curator ad litem, primary carer and advance statements. MHTS statistics from October 2005 to March 2008, relating to patient representation are included, but it is noted that only the last six months of statistics represent an accurate account of legal representation, due to flaws in the older data capture methods. Approximately 20% of patients were represented by a lawyer or curator ad litem over the entire period, where the last six months the figure is 67%. Campbell (2008) reports that in Northern Ireland the vast majority of patients were legally represented, though this is an appeal-based tribunal, unlike the Scottish system which oversees all long-term decision making under the 2003 Act.

In terms of representation, advocates help people to express their views and may help prepare advance statements which set these out in a written format. Lawyers take instruction from and therefore clearly represent the views of patients for tribunals and other legal matters. named persons, however, may form their own view as to what is in the best interests of the person, not unlike Curators ad litem, who are put in place to look after patients' best interests in tribunal processes if they are unable to instruct a lawyer. Dawson et al (2009b) does acknowledge all these roles are distinct from each other, but there is little discussion about potentially complex dynamics between these roles. A few participants criticised the quality of legal representation and suggested that lawyers view tribunals as moneymaking opportunities: although participating named persons reported positive relationships with solicitors. This does not justify the later recommendation to improve legal representation. Whilst advocates' involvement was generally viewed positively, a few MHOs believed advocates sometimes interpret rather than represent patients' views, especially patients with impaired capacity (Dawson et al 2009b), interestingly echoed in MacKay et al (2011) when analysing the 2007 Act.

Conclusions and recommendations relating to named persons

The broad conclusions suggest that named persons are being utilised routinely, whether default or nominated, legal representation is more common in the youngest and oldest age groups and that use of advocacy has steadily increased (Dawson et al 2009b, Atkinson and Berzin 2010, 2009). Interestingly, given the common perception that too many attendees at a tribunal might confuse the patient, none of the reports raised concerns about the possibility of three different people (Named Person, advocate and legal representative) trying to represent the patient's interests. Dawson et al (2009b) and Berzins and Atkinsons (2010; 2009) recommended

various improvements in named person processes, however, in addition Berzins and Atkinsons (2010) with very little justification and on the aforementioned false premise that it was compulsory to have a named person, recommended consideration should be given to abolishing default named person provisions. The express purpose of the new named person role was to provide flexibility about the appointment (Scottish Executive 2001c), so this recommendation seems a retrograde step.

2.11.2.3 Advance statements

Advance statements are also seen as central to involving patients in their own care and treatment (Atkinson 2006; Scottish Executive 2001). Atkinson (2006) incorrectly suggests that where an advance statement under the 2003 Act is in place, treatment consistent with this can be imposed, even if the patient later changes their mind. Indeed, the fact that advance statements cannot be enforced weakens their effectiveness. Atkinson (2006) notes that advance directives, not legally binding in Scotland, allow limitations to be imposed on social behaviours, not just treatment. She suggests that the take-up of advance statements will be a test as to their usefulness. There is very little evidence of either the effectiveness, or the number of statements that are used. Atkinson (2006) accurately predicted problems in terms of monitoring and accessing existing statements due to inadequate systems for logging them. The MWC keeps statistics on numbers ‘overridden’, but gathers no other information on advance statements. Statistics show that only 19 were overridden in 2011 (MWC 2012f). Papageorgiou et al (2002) undertook a longitudinal study over 12 months into advance directives in two London psychiatric services. The study concludes that these had no noticeable impact on outcomes, in terms of involuntary admissions for patients, though the therapeutic relationship between clinician and patient was reportedly enhanced.

2.11.2.4 Bureaucracy

Atkinson et al (2007) undertook a small study into the administration of compulsory powers under the Act examining time demands on professionals and impact on their workloads. She attempted to 'cost' orders under the 2003 Act compared to the 1984 Act, but expressed caution in generalising too much from this small study. 94 questionnaires were returned and 42 staff interviewed, predominantly MHOs and Responsible Medical Officers (RMOs) the lead medical professionals for individuals subject to the 2003 Act.

Unsurprisingly costs under the new Act are reportedly greater as professionals have to dedicate more time to implementing measures (also in Lawton-Smith 2006). A Scottish Government survey which looked at MHO services and structures (Maas-Lowit 2007) reported significant challenges for MHO services in meeting the demands of both the 2000 and 2003 Acts. Atkinson et al (2007) found that although some training was seen as effective, most participants reported that it was experience which helped develop a clear understanding of the issues. Most participants believed that no-one had anticipated the resource demands adequately, particularly in relation to tribunals. Multiple tribunals for each application were seen as particularly problematic, especially as the evidence has to be rehearsed at each tribunal, though the MHTS Annual Report (2013) claims some success in reducing numbers of multiple tribunals. A few respondents claimed that pursuing outcomes perceived as acceptable to tribunals was sometimes preferred to acting in the patient's best interests. MHOs were concerned that demands associated with the 2000 and 2003 Acts meant the vast majority of their time was spent on fulfilling statutory duties rather than on social work practice with the service users concerned

or others on their caseloads. Overall however, participants expressed goodwill towards tribunals and the new Act was viewed positively (Atkinson et al, 2007).

2.11.2.5 Overview of the Act

The higher profile 'early experience' report (Dawson et al 2009a) is in some respects surprisingly negative about the 2003 Act, though caution should be exercised when considering the findings. Although the sample appears to reflect a broad range of experience, the number actually interviewed who had experience of detention or compulsion was only 49 and as the report acknowledges even fewer had experience of attending tribunals. Those who had were from wide-ranging backgrounds, several from the state hospital, some with learning disability and some who acknowledged they had been so ill they had little recollection of the process at all. The overall sample included 49 service users, 23 professionals (including advocates, MHOs, RMOs, CPNs and lawyers) and 33 carers. The involvement of user groups in recruitment and design will have helped ensure a user focus to the results, but the focus is more about treatment than effectiveness of the legislation.

The findings of the report are grouped under key parts of the Act such as tribunals and named persons. Despite the earlier noted intentions around therapeutic jurisprudence (Morrow 2012, Wexler 2000), a few participants described tribunals as adversarial in nature, although most viewed tribunals as an improvement on the court-based system. Named person processes and roles were seen as confusing, concerns again being expressed around information sharing. Carers felt this role helped give them a voice in the process, though reported that tribunals did not necessarily take their input seriously. Advance statements were widely viewed as pointless. Professionals saw changes to compulsion processes as significant, though

this was less clear from the feedback of users and carers, who were more concerned with the outcome, rather than the process. Predictably carers were happier with compulsion outcomes than service users, though service users reported that a year on from a detention they could see the value (reflecting Hoyer's (2000) 'thank you' model). Several service users saw community-based orders as being 'medication' orientated and expected better and many carers agreed, expressing concern about inadequate resourcing. Significant disquiet was reported about hospital-based compulsion, focusing on lack of activity, boredom, and limited opportunity to get off the wards and few reported being involved in developing a holistic care plan. A frightening ward environment was frequently cited and most reported poor follow-up planning on discharge, though this seemed to be better for those subject to community-based orders. Wider social and employment based provision was not viewed to have been enhanced by the Act.

Bearing in mind the earlier note of caution, the emerging themes from patient's perception was that those subject to compulsion were unhappy with this, wanted more control and asserted that their treatment was based on medical models of intervention. Professionals' earlier reported concerns around increased workload for psychiatrists and MHOs (Atkinson et al 2007) were restated in the summary, though supporting data is limited. Others' concerns about a two-tier system (Campbell, Healy and Brophy 2006, Smith 2006) were echoed here, whereby it was perceived greater resources, including advocacy, go to those subject to compulsion. Another major theme was that the overlap between Acts is poorly understood by professionals and that the pending 2007 Act was only going to make this worse. Absence of recovery-based approaches was highlighted and the report recommends

future research should be focusing on outcomes for service users, enhanced inclusion in care planning and effective use of advance statements. This apparent negativity towards the 2003 Act suggests that certain aspects of the legislative framework have not been as universally welcomed as suggested by others (Atkinson 2006, Scottish Government 2011).

2.11.2.6 Reviewing the 2003 Act

The Scottish Government commissioned Professor McManus to chair a limited review of the 2003 Act, focusing on advance statements, independent advocacy, named persons, medical matters and tribunals (Scottish Government 2009). A subsequent wide consultation led to a government action plan (Scottish Government, 2012c), followed by a further consultation (Scottish Government 2013a) resulting in a paper announcing the intention to publish a Mental Health (Bill) 2014 (Scottish Government 2014). The agreed areas are briefly considered below (unless otherwise stated these are detailed in Scottish Government [2014]), along with some of the earlier debate, to illustrate developing perspectives about the Act.

Advance statements

The Government accepts that central records of Advance Statements should be kept, as recommended, and guidance rather than legislation, should encourage statutory authorities to promote their use.

Independent advocacy

No significant changes are proposed, though consideration is being given to providing extra funding to allow carers the right to access advocacy.

Named persons

The Government rejects proposals that named persons must be nominated, retaining the existing default arrangements. Minor amendments will allow a clearer

generalised ‘opt-out’ if the patient does not wish *any* named person and proposed named persons will be required to provide written agreement to their nomination. Proposals to limit the involvement of named persons (Scottish Government 2012c) as highlighted earlier (Atkinson 2010, 2009; Dawson et al 2009b), were not in the McManus Report (Scottish Government 2009) and were ultimately rejected.

Medical input to tribunals

Many stakeholders reportedly had major concerns surrounding the GP role in Compulsory Treatment Orders (Scottish Government 2009). The review recommended that GPs should, as the MHO does currently, comment on the Approved Medical Practitioner (AMP) recommendation for compulsion from their own perspective, rather than provide a report. If there is no GP then in exceptional circumstances this report could be completed, subject to safeguards, by another AMP. In its Action Plan the Government (2012c) proposed instead that should a GP not be available, then the patient or even the tribunal may seek an independent report. However, following overwhelming opposition to these proposals, GP reporting arrangements remain unchanged.

Suspension of detention

Removal of the nine-month limit on suspension of detention has been agreed and, although a technical matter, will help avoid unintended problems where a patient has been allowed to remain out of hospital a few days longer than intended. However, proposals to replace these measures need to be cognisant of problems with open-ended leave of absence under the 1984 Act discussed earlier. Proposals to improve care plan documentation and practice however, were not accepted.

Multiple tribunals

To address perceived concerns about multiple tribunals a controversial change has been accepted, despite its absence in the 2013 consultation proposals (Scottish Government 2013). This would extend the period from 5 to 10 working days, for which a STDC applies, pending a tribunal to consider longer term compulsion (Scottish Government 2009). Theoretically a patient could now be detained under a STDC for 42 days: thereby allowing more time to prepare for tribunals, but simultaneously further compromising patients' civil liberties by delaying access to independent scrutiny of the facts. Perhaps to counter this, the Government has agreed that STDC appeals must be heard before it expires, and that a 28 day time limit be imposed for any other appeal. No proposals about overly formal or legalistic conduct of tribunals, training or venues were accepted by the Scottish Government, though it was recommended such concerns should be addressed by relevant bodies (Scottish Government 2012c).

2.11.2.7 The next steps

Overall the McManus report (Scottish Government 2009) and responses (Scottish Government 2012c, 2013, 2014), provide an interesting longitudinal record of public perceptions of the 2003 Act and its effectiveness. These documents reveal concerns around practicalities rather than fundamental aspects of the legislation and consequently no major amendments are proposed. Given that this limited review was commenced in 2008 and may not bear fruit until 2015, as with the 2000 Act it is unlikely any further major changes will occur in the near future.

2.11.3 Adult Support and Protection (Scotland) Act 2007

2.11.3.1 Introductory comments

Since commencing this research, the 2007 Act has achieved a much higher profile than might have been expected. Little accessible data exists on use of measures under the Act, though a recent review commissioned by the Scottish Government (Ekosgen 2013) includes statistics and provides insight into how the Act is perceived to be working. This will be discussed later as it provides an authoritative, if methodologically limited, commentary. Literature on the 2007 Act rather than providing critical analysis is more practice focused, consisting of interviewing and risk assessment guides, annual reports from Adult Protection Committees and 'explanatory' texts seeking to summarise the measures and intent behind the Act. The critical commentary largely consists of brief journal articles and small-scale studies but the most significant, for this thesis, prior to Ekosgen (2013), is the Mackay et al review (2011).

Mackay et al (2011) reviewed 32 cases across three local authority areas, conducting interviews with 29 staff (27 social workers and two OTs), six service users and one relative. The study set out to explore the assessment and decision-making processes and interventions from a practitioner point of view. Underpinning this, the research explored precipitating factors, user perspectives and also the effectiveness of, and thresholds for, interventions.

The research, primarily qualitative in nature, was based on semi-structured interviews with participants and utilised some publicly available data. Purposive sampling methods were used, seeking to achieve a balanced range of backgrounds,

although professionals were identified by their own management. MacKay et al (2011) emphasised the practitioner focus, drawing the research team from academia and practice. The spread of cases, by client group, and range of situations was diverse, though the claim that these cases are representative of use of the Act is not evidenced. Nevertheless, familiar themes emerged from this study, considered briefly below.

2.11.3.2 Emerging blame culture and defensive practice

MacKay et al (2011) found that many participants fear this Act encourages a blame culture whereby 'tools' appear to be available to minimise or eliminate risk, but may not assist authorities to intervene. One participant observed that "at the end of the day you were carrying a lot of this stuff yourself" (Mackay et al 2011, p4) and another asserts that practitioners or agencies may receive unwanted public attention if they are "perceived to have made the wrong decision" (Mackay et al 2011, p10). This unwanted public attention and 'blame culture' is brought into sharp focus in the review of MWC reports earlier in this Chapter. Mackay et al (2011) cite research demonstrating the dangers of defensive practice and the tendency for authorities and individuals to retreat into safer, procedurally dictated, assessment as opposed to more creative use of clinical judgement, again echoing earlier discussion (Webb 2006; Titterton 2005; Castell 1991). Like Reith (1998) and Stanley and Manthorpe (2001), MacKay et al (2011) observed that the greatest public attention occurs when practitioners get it wrong.

2.11.3.3 Definitional problems

MacKay et al (2011 p10) graphically describe complexities of decision-making in adult protection: "practitioners working under ASPSA, and more generally in social work, occupy what is often a foggy borderland where there is uncertainty about

whether to intervene and what type of action to take". It is argued that over-prescriptive approaches are not helpful and that to some extent this 'fogginess' justifies differing interpretations of when an adult is 'at risk of harm'. Daniel et al (2013) undertook a small-scale qualitative study based on a 'forum theatre' approach involving 42 people with learning disability, who acted out core scenarios to examine risk and the 2007 Act. Participants were critical of the tendency to see adults as 'vulnerable', as this labelled inherent personal characteristics and many believed that the definition of 'adults at risk of harm' (s3, the 2007 Act) at least provided some objectivity in assessment. Others disagreed, as s3(1)(c) refers to inherent characteristics, namely "those affected by disability, mental disorder, illness or physical or mental infirmity". In Sherwood-Johnson's (2013) discussion paper on the construct of vulnerability and Patrick and Smith's (2009) guide to the 2007 Act, it is suggested 'vulnerability' should be seen as external, in relation to circumstances.

2.11.3.4 Capacity and undue pressure

Commentators on the Act (Keenan 2012; Patrick and Smith 2009) are very clear that a sheriff can over-rule consent if a person is seen to be subject to undue pressure (s35(3) 2007 Act), but the issue of capacity is rather more complex. Citing the Code of Practice (para 9.25, 10.24 Scottish Government [2008b]), Patrick and Smith (2009) suggest that where a person lacks capacity, a sheriff would have the power to impose an order under the 2007 Act, but acknowledge that this could be legally contested. As noted earlier no reference is made to capacity, in relation to measures under the Act.

2.11.3.5 Risk of harm

MacKay et al (2011) identified a wide range of harmful behaviours, noting that often more than one type of harm affects the same person. Perpetrators of harm were

largely those that the service user should have been able to trust, for example care providers, or more often relatives, echoing findings in many MWC reports (2006b – 2016b). Daniel et al (2013) advise authorities to be aware that 'adults', deemed 'at risk of harm' from others, are expected to relinquish trust in people they may have known for years, in favour of officials with whom they may have little or no relationship.

Many participants reported facing high risk situations when carrying out assessments, emphasising the need for joint visits for corroboration and safety. This finding is not given prominence in other papers about the Scottish legislative framework, but Davidson and Campbell (2010) found that in 26% of assessments reviewed, ASWs felt at personal risk.

2.11.3.6 Undertaking assessments and investigations

Gathering views from neighbours or estranged relatives was seen to be a difficult ethical area and some participants, echoed in the Ekosgen (2013) study, reported that 'harmers' also sometimes brought benefits for the service user (MacKay et al 2011). The need for management supervision and support was clearly identified, though it was unclear if this was offered. Mackay et al's findings (2011) highlight risks associated with very complex, autonomous decisions being taken by lone practitioners. MacKay (2008) had earlier anticipated difficulties when she argued that the decision to allow less qualified workers to undertake council officer duties is unwise, as the level of risk being dealt with often involves criminal matters and consequently requires the input of experienced professionals. Several inquiries expressed similar concerns about decision-making in the absence of wider scrutiny, but also highlight risk to workers (Reith 1998, Stanley and Manthorpe 2001). In the

context of under-resourcing and poor communication and coordination between different agencies, Davidson and Campbell's (2010) review of ASW assessments similarly raises concerns about risks faced by ASWs, who frequently work alone when undertaking assessments.

2.11.3.7 Thresholds and differential decision-making

Issues around thresholds were highlighted in Mackay et al's (2011) findings. Whilst acknowledging there were insufficient cases to reach firm conclusions, those who had been severely harmed or had come to the attention of the police were brought into the sphere of the 2007 Act on quite a subjective basis, despite attempts to bring objectivity to defining 'adult at risk' and 'harm'. MacKay et al (2011) highlight potential for differential decision-making, in relation to aforementioned issues around capacity and undue pressure, but also due to differing professional thresholds for action, further complicated by issues of lifestyle, culture, gender, health and importantly age. As noted earlier thresholds are key to interpreting criteria for intervention (Davidson and Campbell 2010), so disagreement around this may affect consistent application of the Act.

Participants in MacKay et al's study (2011) reported that senior managers and other agencies, particularly police were more likely to be involved in ASP case conferences, than in similar meetings prior to the 2007 Act. The principle of shared decision-making was reportedly enhanced, likewise participation of the adult at risk of harm. This suggests that Hogg et al's (2009) concerns about poor multi-agency participation have been addressed. Daniel et al's (2013) study reinforces these findings, further suggesting that the quality of intervention affects the outcomes for, and attitudes of, those subject to the Act, echoing earlier noted ideas about the

importance of positive relationships (Campbell and Davidson 2009; Sorgaard 2007; Wexler 2000).

2.11.3.8 Usefulness of adult protection legislation and processes

MacKay et al (2011) echo others' findings (Hiday et al 2002) emphasising the benefit (if not the legal necessity) of voluntary co-operation with measures rather than the use of coercion. The fact that 32 case studies (from three local authorities) involved only one removal order and three banning orders might suggest that voluntary intervention is the norm, however, this oversimplifies matters as the 2000 or 2003 Acts were sometimes used to enforce compliance, using the 2007 Act as a gateway (MacKay et al 2011). How far people are able to give explicit consent to the much larger number of investigations and inquiries undertaken (unidentified in this report) is not explored. Demonstrating the 'foggy' nature of interventions a case is cited where a protection plan was arranged for a man, assessed as being at risk of harm from his wife, but to whom he also presented risks.

Participants viewed Removal Orders as potentially useful for motivating the adult and providing benefits and Banning Orders as offering protection against assault, though routine failure to prosecute abusers was concerning. Most participants believed orders 'lacked teeth' and are complicated to achieve, particularly with limited support from local authority lawyers in the early days of implementation (MacKay et al 2011).

In a more positive light, and rather contradicting reported negative perceptions of many participants, MacKay et al (2011) assert that practitioners generally welcome the new legislative framework, particularly the clarity it brings to rights and duties and

the robust nature of the authority to intervene. This was tempered with reservations about time-consuming processes involved.

Echoing Government aspirations as expressed in codes of practice and themes identified in previous research, MacKay et al (2011) recommend action be taken to promote positive relationships, enhance involvement, self-determination and communication, improve support for staff and increase use of evidence-based practice. Perhaps predictably, the report called for improved relations between NHS and social work and for police and procurator fiscal services to work towards higher conviction rates for abusers. Little agreement emerged around thresholds or what constituted effective intervention, so these are identified as valuable future research topics.

2.11.3.9 Government review of the 2007 Act

The Scottish Government sponsored Ekosgen to evaluate 'provision of support' offered through adult protection procedures. Given the substantial resources deployed in commissioning research by Hogg and Johnson (2009), apparently intended to provide a benchmark for future research into the 2007 Act, it is surprising that the Ekosgen study (2013) does not even mention it.

The remit of the study was more limited than Mackay et al (2011) or Hogg and Johnson (2009) and the methodology substantially different. Ekosgen (2013) utilised data from Phase 1 of the project (Ekosgen 2012) drawn from a 'meta-analysis' of all 32 local authorities' biennial reports (2008-10) and telephone interviews with 11 unidentified 'stakeholders', possibly senior management professionals. In Phase 2, Ekosgen (2013) examined one case study each from ten local authorities, discussing

each with unspecified individuals (by telephone in most cases). In addition, four workshops were hosted across largely urban areas of central Scotland and telephone consultations with stakeholders were undertaken. Workshop participants appeared to be drawn from senior staff across agencies, though this is not explicit, and although two workshops reportedly involved seven and thirteen participants respectively, numbers of workshop participants and telephone consultees were not provided.

In attempting to gauge the effectiveness of 'support provided' Ekosgen (2013) examined perceptions of how the 2007 Act has helped adults at risk, interagency working, operational barriers and suggested areas for reform. Despite the methodological limitations some common themes with Mackay et al (2011) emerged. Participants were positive about the benefits of the Act and it is claimed that it enhances self-esteem and well-being and provides protection from financial and physical harm. The fact these meet National Outcomes Framework targets of healthier, wealthier and safer Scotland (Scottish Government 2007d) would no doubt be welcomed by Government sponsors, but evidence for these claims is limited. A rather surprising claim is made about substantial financial savings resulting from the Act, based on very speculative extrapolations from reported protection of benefits, savings and assets.

Responsibilities under the 2007 Act were viewed by participants, reinforced by documentary analysis, not as a single agency issue, but as part of an increasingly shared agenda, actively involving service users. Some areas reportedly involved service users in designing local policy. Improved attendance at decision-making

meetings is also reported, but echoing others' findings (MacKay et al 2011; Hogg and Johnson 2009) less engagement from GPs and other NHS partners was identified, apparently for "justifiable reasons" (Ekosgen 2013 p30), though these were unexplained.

Reflecting MacKay et al's findings (2011), confusion over capacity issues and difficult dynamics between lifestyle choice and the need for protection, led to questions over which of the 2000 or 2007 Acts should apply, Ethical dilemmas were also identified where there is a perceived benefit for the 'abused' from the 'abuser'. Whilst MacKay et al (2011) are positive about the impact of banning orders, Ekosgen (2013) report concerns that perpetrators of abuse were becoming less inhibited by the possibility of being caught for breaching the conditions. Brief reference is made to a case where the professionals' approach was apparently heavy-handed and inflexible and pursuit of inquiries following false allegations has damaged trust. Again reflecting MacKay et al's (2011) viewpoint, apparent defensive practice by the police is evidenced by overuse of referrals under the Act.

Organisationally it is noted that obtaining information from banks and general inter-agency cooperation has improved though, given that public bodies (s5) and organisations, like banks (s10) are legally required to cooperate and provide relevant information, this might be expected. However, the findings suggest that underlying attitudes have changed, which is clearly positive if true. The creation of Public Protection Units and co-location of services in some areas is viewed as evidence of improved inter-agency co-operation.

Eskogen recommendations

There are only three limited recommendations, following a statement, without supporting evidence, that the Act has the backing of 'the vast majority of people' (Ekosgen 2013 p29). These relate to knowledge, health service engagement and better local information and do not fully reflect areas stakeholders would apparently like to see changed, a missed opportunity given the high profile of this study. One recommendation suggests using newsletters to inform staff, though it is unclear if this is simply the researchers' initiative or arose from data. The next recommendation related to health services, calls for improvements in raising awareness, somewhat contradicting claims from Phase 1 (Ekosgen 2012) that this was a key achievement of Adult Protection Committees. The third recommendation suggests further research is undertaken to provide a better local picture, though it is not clear what this would achieve.

One conclusion, with no related recommendation or obvious solution, suggests that the Act may be "inadvertently transferring harm" (Ekosgen 2013 p21) by closing down one area of potential exploitation, prompting abusers to move on elsewhere. Whilst issues relating to training were highlighted, one participant's interesting perception that access to someone with experience would be more helpful, was not explored in the recommendations. Nor is the assertion that sheriffs do not receive training and may thus be taking different views on issues such as capacity, leading to different outcomes for similar cases. The source for this information is unclear but it echoes concerns noted around sheriff's decisions under the 2000 Act (SLC 2012; Stevenson, Ryan and Anderson 2009) and adds to evidence that may explain differential decision-making across the country.

2.11.4 General issues about the legislative framework

The Government envisaged the three Acts as providing "… a strong legal framework that ensures situations where an adult is being harmed are dealt with properly. …The 2007 Act provides legislative responses for people and situations … not necessarily covered by either of the other Acts … [and] allows councils to make inquiries where they would otherwise have no power to do so… a council may choose to use other parts of the 2007 Act or may choose to respond using another Act or even a non-legislative route" (Scottish Government 2011, no page number).

A key element of this study seeks to understand how far this framework helps practitioners to achieve such objectives. This final section of the literature review therefore examines commentators' views on the overall framework, to provide a link to the primary data collection of this thesis, though there are few research-based studies which address this in any detail.

A number of attempts have been made to compare the three Acts. Gordon (2004) looked at the 2000 and 2003 Acts and MacKay (2008) looked at all three. Whilst Patrick (2009) provides a comprehensive practitioner guide on the 2000 and 2003 Acts, Patrick and Smith's (2009) book tries to pull together all three Acts in a more accessible format. However, these are largely descriptive rather than analytical. Keenan's (2012) book *'Crossing the Acts'*, aimed at "key practitioners", somewhat ambitiously attempts to explain how the legislation interacts and makes links to core aspects of social work practice, however, it is methodologically limited and at times inaccurate. Relevant aspects of these are briefly examined below, alongside related discussion papers and research by other writers. The headings arise from key

features of the literature already reviewed and are closely linked to key practice issues which have emerged.

2.11.4.1 Issues around capacity and significantly impaired decision-making

Gordon (2004), sponsored by the Scottish Executive, undertook a very detailed analysis of both the 2000 and 2003 Act, but this was limited by being desk-based and prior to implementation of the 2003 Act. Briefly mentioned earlier, she suggests that while the 2003 Act includes compulsion for care and treatment the 2000 Act also compels people to accept care, if not treatment, for mental disorder. Gordon (2004) makes the interesting distinction that whilst the 2000 Act makes no reference to service provision, the 2003 Act places duties on NHS and local authorities in various sections. Keenan (2012) highlights this duty to provide services under the 2007 Act, the so-called 'support' element.

Gordon (2004) identifies already conflicting ideas about 'impaired decision-making' under the 2003 Act and 'incapacity' under the 2000 Act, which she describes as essentially decision-based. Stevenson, Ryan and Anderson (2009) add to this definition, citing an unreported Sheriff's decision relating to Guardianship, where a solicitor claimed a patient's capacity was intact. The Sheriff observed that the Act links capacity to the ability to safeguard one's own interests, and in that respect the patient was not capable, and therefore found the assessment of 'incapacity' to be proven.

Gordon (2004) suggests slightly differing definitions of capacity influence which Act applies. For example, compliance with medication might be enforced under the 2003 Act and residence under the 2000 Act, unless the 2000 Act capacity test is not met,

in which case residence may be underpinned by measures under a community-based CTO (also accepted by Brown et al 2012). Gordon (2004) makes the insightful point, given the timing of her paper, that the different decision-making bodies (tribunals and Sheriff Court) may have different views around criteria and may have insufficient knowledge about measures under other Acts, which may partly explain differential application of the law.

Dawson and Szmukler (2006) (a lawyer and psychiatrist respectively) argue strongly for the fusion of incapacity and mental health legislation, in a frequently cited discussion paper. This would enable compulsory treatment for physical, as well as mental disorder, making links to incapacity. The 2000 Act does to some extent allow for this as incapacity may arise from inability to communicate due to physical disability (s1(6)). Dawson and Szmukler (2006) argue, however, that mental disturbance is a feature in any decision to refuse treatment whether for physical or mental illness and that incapacity should be the criteria for intervention, rather than risk to self or others (as in the 2003 Act). They further suggest that their approach would allow those deemed to 'have capacity' to be dealt with under the criminal justice system where appropriate, dealing with some of the concerns raised previously around the interface between mental health and criminal justice services (Greig 2002; Bean 2001; Prins 1995). Whilst suggesting that capacity is difficult to assess, if not directly linked to mental disorder, it is claimed that high levels of reliability in capacity assessment can be achieved with relatively limited training of medical professionals (Dawson and Szmukler 2006). It is acknowledged, but not really addressed, that there is potential for unreliable or subjective assessments of capacity, a serious concern in terms of civil rights. The discussion focuses almost

entirely on the debate around English law and lack of reference to the 2000 Act seems a serious omission given the common concerns about these issues across the UK. Their paper nevertheless anticipates difficulties over use of force, identified in many later inquiries (MWC 2012c, 2011b; Scottish Courts 2007).

The term ‘capacity’ is only used in the 2003 Act to understanding the consequences of making an Advance Statement in Part 17. The term ‘capacity’ does not appear at all in Part 1 of the 2007 Act, which deals with all the new measures. The 2003 Act Code of Practice (Scottish Executive 2005d) distinguishes between incapacity of the mind and the brain, in a similar (somewhat over-simplified) way to the MCA 2005, the 2000 Act dealing with the brain and the 2003 Act the mind. An article by Chiswick (2005) highlights continuing misunderstanding around these issues. Referring to the third criteria for compulsion, ‘significantly impaired decision-making’ (2003 Act), he states that a ‘capacity test’ is not helpful in deciding whether or not a patient should be subject to compulsion. This contrasts with earlier reported approaches across several countries where ‘incapacity’ is seen as an essential criterion to justify compulsion (Dawson and Szmukler 2006; Bean 2001). Hopefully most people now agree, through testing at tribunals not least, that this ‘capacity test’ for the 2003 Act, if indeed it is that, is very different from the capacity test in s1(6) of the 2000 Act, or indeed the susceptibility to ‘undue pressure’ criteria which underpins 2007 Act interventions.

The criterion ‘significantly impaired decision-making’ relates to the ability to make a rational, as opposed to illness-driven, decision to refuse treatment (Patrick 2009). The 2003 Act Code of Practice (Scottish Executive 2005d) emphasises this does not

simply mean that the patient disagrees with the doctor. Although parallels are drawn with ‘capacity’ in the 2000 Act, impaired decision-making must link directly to refusal to accept treatment for mental disorder and the Code suggests that input of a psychologist may be helpful (Scottish Executive 2005d). Patrick (2009) asserts that there is considerably more flexibility around defining impaired decision-making in the 2003 Act compared with incapacity in the 2000 Act, suggesting developing case law may assist. She gives an example of a person with depression who refuses treatment because they wish to die or feel ‘unworthy’ noting “it is not clear whether such a person lacks legal capacity, but clearly the person’s ability to take medical decisions is significantly impaired because of the depression” (Patrick 2009, p170). Patrick (2009) goes on to suggest it may be a rational decision to take one’s own life, but does not give any examples. Given this advice is in the context of a book purporting to provide guidance to professionals, such statements are unhelpful, potentially raising significant ethical dilemmas for those exercising powers under the 2003 Act. Countries such as the Netherlands do permit assisted suicide in certain circumstances, but this is not the same as the state failing to intervene to prevent someone taking their own life.

Richardson (2007) discusses justification for compulsion in mental health citing developments in English law and examines the capacity debate. Like Dawson and Szmukler (2006) she proposes a single incapacity framework; however, she warns of the danger over-simplifying this complex area, in an effort to avoid discrimination. In particular, she highlights the problems of ‘preventative detention’, which she argues perplexed legislators in England. She emphasises the important distinction between legal capacity and impaired decision-making in the context of mental health law,

though interestingly Patrick (2009) does not view ‘significantly impaired decision-making’ as a legal term. Gordon (2004) also highlights conflicting ideas around capacity and impaired decision-making in the 2000 and 2003 Acts. Richardson (2007) argues that, law prioritises benefit to the patient over their apparently competent decision to refuse treatment in relation to mental health but not for physical illness. Again echoing Dawson and Szmukler (2006), she highlights potential for discrimination in citing mental illness as a risk factor meriting preventative treatment and even more so, in the case of risk of violence to others. Richardson (2007) implies that psychiatric services seek to limit where this connection is made, whilst legislators and criminal justice services seek to widen the net, particularly in relation to violent and sexual offences. This is underpinned by concerns outlined earlier that psychiatrists may become jailors (Greig 2002; Prins 1995). Richardson (2007) highlights another core justification for coercion, linked to capacity, which is to facilitate access to resources where the person themselves is unable to maintain or make that decision. Whilst this has its merits in terms of helping people access services, like others she reflects on the right of all citizens to equal treatment in accessing services (Sorgaard 2007; Dawson and Szmukler 2006).

Exemplifying the complex debate in dealing with incapacity issues, Patrick and Smith (2009), suggest that it may be possible to appoint a welfare guardian under the 2000 Act who could then consent to an order under the 2007 Act, on the grounds that ‘incapacity’ is not explicitly dealt with under that Act. This book also purports to guide professionals in use of legislation, yet this seems an unduly convoluted approach which potentially conflicts with least restrictive principles. A welfare guardian under

the 2000 Act would be able to exercise wide-ranging powers, assuming the Sheriff grants these, without the need to use the 2007 Act.

2.11.4.2 Managing risk across the legislative framework

Keenan (2012) gives extensive coverage to risk management but the discussion is more about social work practice and is only tenuously linked to the legislation. Patrick and Smith (2009) acknowledge the earlier noted complexities of balancing 'benefit' principles, where the perpetrator of abuse may also provide support (Ekosgen 2013), but do not suggest how the legal framework might address this, nor do they discuss the complexities of assessing risk in such situations. Patrick (2009) does take this further and interestingly recommends that MWC advice (predating the 2003 Act) on risk management should be heeded, whereby if the risk is neither immediate, nor life-threatening it may still be possible to invoke legislation on the grounds of *significant* risk.

Despite concerns that the 2000 Act does not contain urgent measures to deal with immediate risk, Keenan (2012) argues that local authorities have been able to fast-track guardianship applications, utilising interim orders to achieve more rapid responses to crises.

2.11.4.3 Issues around criminal justice

There is no research, and little discussion, in available literature around the interface of the Acts in relation to criminal justice matters. Whilst several of the sources mentioned at the outset of this section refer to offences under the different Acts, only Patrick (2009) examines criminal procedures and processes under the 2000 and 2003 Acts, though given that this is a guide for practitioners the focus is mainly on describing the measures.

It is concerning that Patrick and Smith (2009), like Ekosgen (2013), blame social work for failing to report crimes to the police (in both cases directly referencing the Justice Denied report [MWC 2008b]) without considering the police or procurators fiscal role in this process. The MWC asserted that many people with learning disability are not taken seriously when reporting a crime and are not seen as reliable witnesses by police or prosecutors (MWC 2008b). Measures such as the Vulnerable Witnesses (Scotland) Act 2004 established a mechanism to support people with learning disability as witnesses. The Appropriate Adult scheme, which supports 'vulnerable' people during processes associated with investigating and prosecuting crime, was also reformed, following research commissioned by the Scottish Executive by Thomson, Galt and Darjee (2004). The scheme has apparently been 'professionalised' and more widespread availability and proper training for Appropriate Adults has been achieved, though the development of national standards remains an aspirational aim of the Scottish Appropriate Adult Network (Scottish Government, 2012e).

2.11.4.4 Making inquiries under the Acts

Gordon (2004) highlights inconsistencies relating to duties to inquire (s33, 2003 Act) and duties to investigate (s10, 2000 Act). The local authority duty to make inquiries (s4, 2007 Act) arguably further confuses the picture. Patrick and Smith (2009) and Keenan (2012) try to provide recommendations about how this should be approached, but acknowledge the law itself is unclear and that procedures are largely dictated by local policy and preference. Whilst the 2003 and 2007 Acts include the facility to obtain warrants, to gain entry and enforce compliance (albeit differently expressed and involving different processes), the 2000 Act does not.

Notwithstanding confusion about which Act applies Gordon (2004) goes on to highlight lack of clarity between the OPG and Local Authority over responsibility for investigations and suggests this is poorly defined. The 2000 and 2003 Acts refer to the duty to investigate, where issues arise around finance or welfare, yet the 2003 Act makes no reference to the potential role of the OPG. Gordon (2004) might have made more of this by examining implications around information sharing, thresholds, budget and workload issues. She might also have looked at the changing role of the MWC as the legislative framework has unfolded. She does, however, highlight the odd omission of the MWC's duty to promote best practice in the 2000 Act, where it is clearly stated both in the 1984 and 2003 Acts.

Patrick and Smith (2009) suggest local authorities may need to access legal advice to determine the best course of action in investigations. They also make passing reference to issues of consent, however, this is a potentially very difficult area not highlighted in any of the research discussed under the 2007 Act. If capacity to consent to an investigation is in doubt, then the 2000 or 2003 powers of inquiry may be more appropriate. No statistical data is gathered in relation to investigative powers, but it appears that 2007 Act has become the usual route for initial inquiries despite doubts about consent. The 2007 Act has consequently become the gateway to other Acts (Ekosgen 2013; MacKay et al 2011). None of the available research appears to be questioning how far such inquiries impinge on rights to privacy (Article 8, ECHR 1950). Furthermore, whilst all the books noted refer to different regulators having roles under the framework including the OPG, MWC, Care Inspectorate, none provide any critical analysis of how these organisations carry out their functions (Keenan 2012; Patrick 2009; Patrick and Smith 2009).

2.11.4.5 Interagency aspects

Patrick and Smith (2009) highlight the important point that whilst local authority has the lead role, the ability to intervene effectively depends on the co-operation of others. Beyond this, again, few of the commentators provide any critical analysis of the role of other agencies, instead providing descriptive accounts of their individual roles under the Acts.

2.11.4.6 Role of proxies and relatives

Although Gordon (2004) looked at the functions of named person, nearest relative and primary carer no comment is offered on the potential for conflict. The fact that the 2000 Act requires consultation with all three, as opposed to merely the named person in the 2003 Act, is not discussed. She does highlight the importance of clear processes for seeking welfare proxies' consent to treatment. Dawson et al (2009a) and Atkinson (2006) explore dilemmas around involvement of relatives and carers under the 2003 Act, but not the 2000 Act and do not really address the interface issues.

Gordon (2004) considers issues around representation, noting that only the 2003 Act requires the provision of an advocate (s259). She suggests inherent weaknesses of advance statements may be mitigated by the principle that past and present wishes of the adult must be taken into account (2000 and 2003 Acts).

2.11.4.7 The interface between the Acts and consideration of principles

MacKay wrote a discussion paper (2008) seeking to highlight interactions between the three Acts and argues for an effective strategy to bring these pieces of law together. This was a little premature in that no real idea about the effectiveness of the individual pieces of legislation was established at this stage (or indeed since apparently), hence an overarching strategy is bound to be flawed. Like Reith (1998),

MacKay (2008) highlights the need to learn from past failures, citing amongst others the earlier noted Donnet inquiry (Scottish Courts 2007). Her commentary on the Donnet inquiry accepts without question the local authority's lack of knowledge of the 2000 Act, despite the fact that Part 5 was barely implemented by the time of his death. The Sheriff's assertion that guardianship should have been in place and would have made doctors work better together is also accepted uncritically. MacKay (2008) later identifies, without supporting evidence, a tendency of experienced workers to relish getting bogged down in detail, suggesting that clearer focus on principles would help. This assertion potentially underplays the need to ensure proper processes are adhered to and those subject to orders have their legal rights protected, additionally running the risk of reinforcing 'anti-lawyer' sentiment. However, like Keenan (2012) and Patrick and Smith (2009) she suggests use of principles can help facilitate solutions.

Mackay (2008) argues that the Scottish Government avoided problems in drafting the law in England and Wales with the 2000 and 2003 Acts, by utilising a more inclusive, rights-based perspective and avoiding reference to indefinite detention. However, she also asserts that the 2007 Act reawakened controversial issues around state intervention and that deprivation of liberty was not yet addressed by the Scottish legal framework.

Gordon (2004) questions which Act is least restrictive, highlighting the potential for conflicting principles, if both Acts were used simultaneously. MacKay (2008) addresses this issue by means of a 'pyramid' model which sought to place measures under the Acts in a hierarchy of restrictiveness. Although she claims this model has

been developed and used in a range of educational settings, she provides neither evaluation of its utility, nor information about the extent of its use. The hierarchy is rather imprecise about particular measures under the 2000 Act, but broadly suggests the 2007 Act is lower in the hierarchy, on the grounds that any intervention is short term, or in the case of banning orders may be long term, but does not necessarily unduly limit freedoms. The 2003 Act on the other hand appears at the apex of the pyramid on the grounds that it can authorise detention in hospital. These levels are essentially concerned with the proximity of intervention and the outcome. At the lowest end of the scale duty to inquire is viewed as least restrictive, because it can happen from an office base where assessment at home is more restrictive because it invades someone's privacy. Potential use of force locates removal orders, for assessment or to a place of safety, at the next level of restrictiveness, followed by banning orders as these can inhibit freedom of association. The three highest levels relate to the long-term provision of care at home, being placed in a care home or admitted to hospital respectively. However, these ideas oversimplify complex matters. The level of intrusion of an investigation may be substantial, even where access to someone's house is not gained. Brief removal to a place of safety may result in huge gains for someone's personal freedom, if the grip of an overbearing or abusive carer is broken by this action. On the other hand, a warrant used to enforce entry for assessment purposes surely constitutes a significant infringement of someone's liberty, perhaps considerably more so than long-term provision of community-based services. Mackay (2008) asserts that a community-based CTO, rather than guardianship under the 2000 Act, is the optimum way to underpin a person's human rights where a nursing home placement utilises restrictive measures. If a person's rights are better protected by the 2003 Act, then placing this

above the 2000 Act in terms of restrictiveness in the pyramid model, is surely erroneous.

The pyramid model does not take account of the implied hierarchy in the 2000 Act, whereby power of attorney is least restrictive, because the granter assigns this when capable of deciding and guardianship the most restrictive, since it potentially contains draconian powers over which the adult has no control. Even this is not straightforward, as conversely guardianship might be used to enhance someone's freedom, where a power of attorney might be used to secure a restrictive nursing home environment.

Consideration also needs to be given as to whether there is a real choice between measures under different Acts. There is clearly discretion over which Act can authorise investigation, but for interventions, the criteria will significantly limit which measures can be used. However, the benefit of reflection on the restrictive nature of some of these measures in training might help professionals to appreciate the considerable power authorities can exercise under these Acts, and it is clearly useful to try and think through possible interplay between these pieces of legislation.

Keenan (2012) provides the most recent views on the interaction between the Acts, though the focus is quite descriptive and he seeks, like Patrick (2009) and Patrick and Smith (2009), to clarify practice issues rather than evaluate the framework. Keenan was a MWC commissioner for 8 years and leans heavily on MWC reports to present critiques of practice. Keenan (2012) provides numerous tables, diagrams and 'practice points' boxes to highlight parallels between the Acts, but mainly these

relate to comparing actual sections of the Acts or are based on his views of how the Acts should interact. Keenan (2012) cites very little research and none has been carried out by the author himself, for the purpose of his book.

Given that Patrick and Smith (2009), Patrick (2009) and Keenan (2012) spend some time examining the principles across the three Acts, and despite the earlier noted increasing focus on public protection (Campbell and Davidson 2009), it is surprising that none of these writers refer to the fact that none of the Acts contain public protection principles.

2.11.4.8 Best interests

A final point partly linked to the principles is the concept of 'best interests'. This phrase is often misused, for example Stevenson, Ryan and Anderson (2009) note that this term is often used in court judgements, but it does not appear in any of the three Acts, although it does in the MHA 2007 and MCA 2005. The term 'substituted judgement' is preferred, in that it better describes the role of the proxy under the 2000 Act, though neither term is viewed by Stevenson, Ryan and Anderson (2009) to be an effective standard. It is noted that proxies often do not understand what the adult would have wanted and often underestimate the self-efficacy of service users. This echoes Berzin and Atkinson's (2009a) findings, in relation to named persons, that 'patients' did not trust relatives to act on their behalf. A key point made by Stevenson, Ryan and Anderson (2009) however, was that 'best interests' is not an appropriate standpoint for making decisions for adults as it is essentially patronising and paternalistic. Campbell and Davidson (2009) also question in whose interests decisions are really being taken, noting that dependence on principles alone is not enough to protect the rights of those subject to legal measures.

The English Office of the Public Guardian commissioned an extensive study into best-interests decision-making in complex cases relating to the MCA 2005 (Brown and Marchant 2011). This study examined 60 cases and identified a range of difficulties which could equally apply to invoking legislation in Scotland. These included concerns around assessments of capacity, problems with thresholds and interestingly the emotional component for the decision-maker.

Thus, as a final note of caution in looking at this Scottish legislative framework, it is important to emphasise that decisions are based not on 'best interest principles' but on a legal framework which contains legal principles and a range of checks and balances, some of which appear to be better than others. Writing prior to the 2007 Act, Campbell et al (2006) were certainly positive about the rigorous criteria for compulsion within the legal framework in Scotland.

2.12 Links to the thesis

This substantial review of literature provides an overview of the debates relating to mental illness, incapacity and 'madness' from a historical and current perspective. This was followed by consideration of complex issues around treatment for mental disorder, including medication, psychological therapies and social interventions. This is intended to help contextualise the Scottish legislative framework. The role of psychiatrists and social work services were also considered, as these agencies have primary responsibility for implementing the legislative framework. Issues relating to risk, the rationale and justification for the use of compulsory measures have also

been considered in some detail, as these are the foundation stones for any mental health law. MWC inquiries have been analysed providing insight into the operation of the legislative framework and the MWC itself. The developing Scottish legal framework has been considered alongside international law in countries with similar cultural norms. Detailed consideration has then been given to recent literature relating to the current framework.

This thesis seeks to provide an understanding of the Scottish legal framework from the perspective of those undertaking local authority functions. Given the complexity of the issues it is hoped this comprehensive review of literature sets an appropriate context to enable the reader to understand the data presented and provide underpinning evidence for the subsequent discussion and recommendations.

Chapter 3

Methodology

3.0 METHODOLOGY

3.1 Choice of research approach

This thesis is based on empirical research, which is cross-sectional in design and is predominantly exploratory and qualitative in nature. As outlined in the rationale I had a central role in local authority, providing advice and guidance about this framework. In undertaking this study, I sought to gain a clearer understanding about perceptions and use of the framework, from the perspective of those discharging related local authority functions. The group of staff targeted here are those whose voice is not widely heard in research into this topic area, so I considered an empirical approach essential. There was no obvious benefit to a longitudinal study as the question is not about how participants' views develop over time, but more about the nature of their views and how this impacts on their actions. Qualitative approaches allow greater flexibility than quantitative approaches as the data is "non-numeric and less structured" (Guest, MacQueen and Namey 2012 p4). To set the context and contribute to the overall rationale, quantitative data has been gathered from publicly available sources including, local and national government statistics. This also assisted in directing my inquiries and developing appropriate questions for the focus groups (Creswell et al 2011; Bryman 2008). For example, the expressed views of participants about use of the legislation might help understand the wide variation in its usage across Scotland, albeit there may be other, as yet undiscovered, reasons.

3.2 Conceptual framework

Reflecting on underpinning theories relating to qualitative approaches, Johnson, Onwuegbuzie and Turner (2007) helpfully point out that like quantitative and mixed methods, these include “assumptions, principles, and values … and practice-related issues as parts of the research paradigm” (Johnson, Onwuegbuzie and Turner 2007 p118). Punch (2014) refers to the importance of setting out the conceptual framework to provide greater clarity about the intentions of the researcher. Before discussing the detail of the methodology, to explicitly address these areas, I will outline the underpinning conceptual framework and my own perspective and assumptions.

Guest, MacQueen and Namey (2012) suggest that where a study is exploratory in nature, it is likely to be an inductive research process which might lend itself to a grounded theory approach. However, there is an inescapably evaluative element within this study, specifically, gathering perceptions about the usefulness of legislation through discussing practice experience of participants. It is acknowledged that only limited generalisations can be made about effectiveness from this small sample, but Moule and Hek (2011) identify an increasing trend towards evaluating the effectiveness of interventions, through evaluating practice perception of law and policy.

The research title is not framed as a hypothesis, for example as to the helpfulness or otherwise of the framework, thus it is not experimental, however, I have sought to test out some ideas as noted in the rationale. Guest, MacQueen and Namey (2012) acknowledge there is room for this more confirmatory approach in exploratory

studies. As noted in the aims and objectives, and as evidenced by the purposive sample group, the ideas I have included for testing out relate to training, knowledge and accepted practice, all of which I believed might influence participants' perception of the framework (Alston and Bowles 2003). Guest, MacQueen and Namey (2012) suggest these areas are best explored by qualitative methods, however, I have also sought to keep an open mind to areas which I had not directly considered exploring. For example, although two of the case studies utilised in focus groups, featured involvement of relatives, no specific questions sought feedback on this. An inductive process following analysis of emerging themes in the data (Braun and Clarke 2006) highlighted that this was a complex issue of importance to most participants. The significance of carers' involvement was further emphasised in literature sources (MWC 2006b – 2016b; Berzins and Atkinson 2009, 2010; Dawson et al 2009a).

Reflecting on the theoretical stance of this research, I have considered the value of constructionist and ethnographic perspectives. From an ethnographic perspective the sample group are broadly from two professional groupings: those with responsibility for assessing and managing community care arrangements and those with an MHO background. These are not mutually exclusive groups, but there are clear cultural differences in the roles: MHOs are focused on use of compulsion in relation to protection, care and treatment, whereas those undertaking care management have primary responsibility for identifying and meeting need, in the context of arranging care. Participants are drawn not only from specific professional groupings but also have specific specialist knowledge, two areas where ethnographic approaches to data analysis might be helpful (Punch 2014). From a 'constructionist' perspective it may be that these groups have developed their own

set of beliefs or constructs around the legal framework. Understanding the basis of these constructs, may shed light on the differential use of the framework. This constructionist element can be viewed as an aspect of symbolic interactionism, whereby participants' reality is 'constructed and reconstructed on the basis of [their] interpretations' (Punch 2014 p126). These perspectives are essentially interpretivist in nature, as they explore the meanings that participants attach to the issues under investigation.

This study however, seeks to gain a broader perspective in understanding use of the framework from the perspective of these practitioner groups. Guest, MacQueen and Namey (2012) are very clear that qualitative studies may have 'positivist' aspects, even if the primary position is 'interpretivist'. Whilst limited attempts are made at attaching numerical value to the findings, in terms of this study, understanding participant's beliefs about the legislative framework and how they interpret it are the key objectives. The identification of themes in this context is therefore necessarily a selective and interpretive process (Guest, MacQueen and Namey 2012).

There is debate amongst researchers around the "divide" between the interpretive and positivist approaches. Guest, MacQueen and Namey (2012) regard value-free interpretive research as impossible, because every researcher brings preconceptions and interpretations to the problem being studied. "The term 'hermeneutical circle' or situation refers to this basic fact of research. All scholars are caught in the circle of interpretation and can never be free of the hermeneutical situation" (Denzin 1989 p23 in Patton 1999 p1204). To address this, it is argued that scholars must state beforehand their prior interpretations of the phenomenon being

investigated to bring clarity and avoid misunderstanding. I have done this, as part of identifying ideas to be tested out, in the introductory chapter of this thesis (Patton 1999).

Interpretive Phenomenological Analysis has as its primary goal to describe and understand how people feel, think and behave within a particular context, relative to a specific research question. The approach used here and explored in greater detail under the data analysis subsection is applied thematic analysis “which is similar to phenomenology, in that it seeks to understand the meanings that people give to their lived experiences and social reality” (Schutz 1962 p59 in Guest, MacQueen and Namey 2012 p13. In accordance with applied thematic analysis theory, this research additionally seeks to identify themes within the data directly linked to the research topic (Guest, MacQueen and Namey 2012), for example use of the legislative framework. Whilst understanding the actions of participants, in the context of their beliefs, values and knowledge base, is a matter of great interest and may underpin some of the recommendations, the influence of policymakers and managers is also relevant. This research seeks to understand the impact of all these factors on use of the framework, and in as far as it is possible to establish, the impact on those who are supposed to be protected by this legal framework. Many participants held strong views on structural and political issues and these were often debated from different perspectives within the focus groups. The importance of these areas became clearer as the study unfolded and these are explicitly reflected upon in the discussion of the findings.

To summarise then the conceptual framework is essentially exploratory, qualitative and interpretive in nature and is underpinned by ideas around ethnographic, phenomenological and constructionist principles. Use of these different perspectives on interpreting participants' responses, along with clear statements about the assumptions being made and use of available quantitative data to set out the context, can be seen as theoretical triangulation. Denzin 1978 (in Johnson, Onwuegbuzie and Turner 2007) and Patten 1999, assert that theoretical triangulation can help bring credibility and depth to data analysis.

3.3 The influence of the researcher

Throughout the methodological review in relation to this thesis I will be identifying areas where my own involvement in the field and the consequent potential for bias requires to be addressed. Reflecting on this 'positionality' of the researcher is a core aspect of qualitative research (Orne and Bell 2015). Tufford and Newman (2010) bring together and evaluate a range of ideas around the concept of 'bracketing', whereby the researcher identifies ways of setting his own preconceptions, and possibly those of participants, to one side, to foster greater validity of findings. There are two opposing positions on this, on the one hand Tufford and Newman cite Husserl, viewed as the founder of the concept, and on the other they paraphrase Heidegger's opposing argument that "fully comprehending the lived experience was, in essence, an interpretative process and that bracketing out preconceptions was neither possible nor desirable" (Tufford and Newman 2010, p82). This discussion will be returned to in the context of my own positionality.

I was very conscious that I was perceived by participants in my own local authority as having expertise in the field and that my professional role would potentially lead participants in other areas to assume expertise. Participants may for this reason have wanted to avoid appearing to be ignorant of their duties or becoming liable to censure by myself as researcher. In guidelines for nurse-researchers, Jack (2008) emphasises the importance of how the researcher introduces himself to the participants and reflects on the appropriate use of self-disclosure. I ensured from the outset that I openly acknowledged my interest, and therefore potential bias, but highlighted the fact that my research was entirely independent of local authority and that no conditions or any form of editorial control had been imposed by employers. I further acknowledged I had concerns about the ability of the legislative framework to achieve its stated aims, but that this was based on anecdotal evidence from practice and very limited commentary or research. I explained that the point of my research was to reflect the views of practitioners, in the forefront of delivering on this agenda, as to what is really happening in practice. Information sheets clarified that the purpose of this study was not to challenge or seek out bad practice but to reflect participants' views on the complex issues involved. Tufford and Newman (2010) highlight the benefit of a closely involved researcher in enabling otherwise excluded voices to be heard. I agree and contend that the views of the identified sample group are poorly represented in existing research, and even more so in the development of policy and law, and that they can therefore be seen as an excluded group.

I am not however, suggesting that a subjective viewpoint is desirable in this research, rather I acknowledge that while it is not possible to fully set aside my own perspectives, I found utilising concepts of bracketing helpful in maintaining objectivity

(Tufford and Newman 2010). Mindful of the need to be explicit about any potential bias, bracketing principles have been integrated into every stage of this research project.

The input of colleagues in the early developmental stages and academic supervisors in the later stages has helped to challenge my preconceptions and bring objectivity to the process. I presented to six student forums throughout the process, which helped me become practised in separating my own views, from those of participants' whose views I intended to reflect. I also maintained ongoing reflective, contemporaneous notes as a reminder, to ensure potential bias was addressed or acknowledged (Tufford and Newman 2010). As Whittaker (2012 p98) notes, reflexivity "…is about … questioning your own assumptions and views and being open about these in your analysis".

Moving on through the process, the data collection tool and the analytical approach were chosen to minimise the potential for bias. The data collection tool was focus groups, the rationale for which is discussed in Section 3.7. In terms of 'bracketing', focus groups enable researchers to adopt a more detached role, allowing the participants to take a greater lead in directing the group discussion. The use of case studies, discussed in Section 3.6, allows researchers to direct groups with minimal verbal input.

When presenting the results, I tried to keep voices of participants to the fore by including a substantial range of direct quotes. Cordon and Sainsbury (2006) put forward a number of purposes for including verbatim quotes in qualitative research,

including providing supporting evidence, to deepen understanding of complex issues and to give the participants a voice in the process. The quotes provided allow the reader of this thesis to draw their own conclusions about the meaning attached to participants' comments. There is clearly still potential for selectivity here, but as Cordon and Sainsbury (2006) note approaching this in an honest and transparent manner can counter this concern. I was clear that from an ethical standpoint the full range of views expressed should be reflected in the results. With regard to the process of data analysis, the approach taken is quite mechanistic, relying on a systematic coding and revision process which extracts common data and exceptions in a pseudo-scientific manner. This approach explained in some detail later in Section 3.12, helps to reinforce objective analysis of the data.

In conclusion rather than introduce bias my experience in this area can instil confidence in the reader as to the relevance and validity of the findings. Throughout the process of completing this thesis, use of supervision and repeated proof reading has minimised the likelihood of unintended bias. Although this is my own research, as noted in the letter to Directors of Social Work, I have over time discussed perceptions of the legislative framework at length with stakeholders from many disciplines as well as with service users and carers. Use of this legislative framework underpinned the majority of my day-to-day work for the 10 years between the enactment of the 2000 Act and when I left local authority. I took over running the North of Scotland MHO course in my new role as social work lecturer and continued to sit on Mental Health Tribunals so my knowledge remains current. I have addressed issues around my own perspective in the rationale so will not revisit this further here. 50% of the fees for this study were met by my employers and the

remainder of the costs were met by me personally. Neither of my employers has sought to exert influence over this research nor claims any rights to its use.

3.3.1 Instrumentation effects

On a final note in relation to my own perspective it is acknowledged that over time my own role has changed, with potential for or so-called instrumentation effects. The researcher is seen as the measurement instrument and changes affecting the researcher potentially affect the research itself (Punch 2014). My employment situation had not changed significantly from commencing the research to the data collection phase in 2009. However, major changes between my last year at local authority and my new post as lecturer in social work, between 2009 and 2012 resulted in reduced capacity to maintain my studies. There was therefore a lengthy gap between transcribing the data and commencing analysis in late 2012 resulting in the first submission being early 2014. Now three years later following the relapse of major illness since early 2016, I have gradually returned to revising the content, as my condition has allowed. On a positive note this has allowed for lengthy reflection when reviewing this thesis and the post-viva comments, but the main underlying issues under scrutiny remain substantially unchanged. Examples of this are outlined in the conclusions section.

3.4 Ethical issues

A number of ethical issues were considered in undertaking this research. The University ethical approval form was completed and approved before commencing data gathering. I was mindful of Codes of Ethics (BASW 2011, ESRC 2012), particularly with regard to the requirements to avoid harm, to achieve full and informed participation and strive for honest and full reporting of the findings.

As noted in the section on influence of the researcher, I had to consider, acknowledge and minimise bias as appropriate (Barbour 2008; Tufford and Newman 2010). The Participant Information Sheet (Appendix 2) made clear to participants that disclosure of information which could cause significant harm to another would need to be acted upon (BASW 2011). When introducing the groups I ensured that a confidentiality agreement was reached with participants that others' comments would not be disclosed outwith the group.

To achieve informed consent, the information sheet and consent form set out the purpose of the research and addressed a range of issues, including confidentiality, anonymity, storage, use of data, access to support and the right to withdraw. This was further clarified in letters to Directors of Social Work (Appendix 1) seeking permission for this project. From an ethical perspective I acknowledge that assumptions were made that participants were sufficiently experienced to contribute to the debate. There is a degree of selectivity here which could have been influenced by my own views of what is important in this legislation, however, the staff group accessed were from different sections of social work departments and broadly reflected those most likely to be using the Acts in their day-to-day work. Participants were also self-selecting and no-one was excluded, providing they had a clear role to play in application of the law. To ensure readers are aware of my own background and perspective I have made clear statements about these matters in the introductory sections and the early part of this methodology section. For participants the information sheet and covering letter to Directors (Appendix 1) clarified the issues I was seeking to explore and my own position in the system.

The initial intention was to name the local authorities in the study, to allow readers to access publicly available research data relating to each authority. However, participants were unexpectedly frank in their criticisms of their own authorities and other stakeholders, so given the potential for individuals carrying out very specific roles to be identified, or for local authorities to be criticised, I decided to extend the anonymity to local authority level.

Literature was predominantly sourced from respected academic writers, peer reviewed journals or public policy/discussion documents, unless a specific purpose was served by using materials from elsewhere. In all cases the sources were made explicit. Findings from the literature and from the focus group are reported fully, even where this may shed doubt on the main findings of the research. Where these differences exist these have been highlighted and contextualised appropriately.

Use of language throughout has been respectful towards people with mental health problems in recognition of the stigma and labelling that is experienced by this group (Rogers and Pilgrim 2001). I believe this element is often not taken sufficiently seriously, as negative images are often subtly expressed in professional groupings and can easily be inadvertently reinforced by ill-considered interpretation of findings or loose use of language. I did not filter verbatim quotes in any way, but highlighted potentially discriminatory stand-points and used appropriate language in constructing related narrative.

The transcribed data gathered from the groups has been 'pass-worded' and kept on my personal computer. The actual digitised recordings have been kept in a locked drawer along with signed consent forms.

3.5 Identifying the sample

The staff groups targeted were those I believed to be most directly concerned with carrying out local authority functions under the legislative framework. As I examined this more closely it was clear there were many variables even among this group, but it seemed that there were two related core functions of frontline staff in this regard. These are Mental Health Officers (MHOs) who are allocated specific tasks in the 2000 and 2003 Acts and those I describe as care managers who have less clearly defined roles under all three Acts.

3.5.1 Defining 'care managers'

Within local authorities the responsibility for implementing community care policies lies with community care teams, supported by management, training staff and legal departments. Following implementation of the NHS and Community Care Act 1990 (the 1990 Act) the job title 'care manager' was introduced and qualified nurses and occupational therapists were recruited to work alongside social workers undertaking this role. The role involved assessing and arranging for the provision of care for adults, whether at home or in care establishments. Since the so-called *21st Century review of Social Work* in 2006 (Scottish Executive 2006b) many local authorities only recruit social workers to care manager posts and the job title varies even between these three areas. For simplicity the term 'care manager' will be used here, to distinguish this staff group from practising MHOs. Child care workers were not

included as they have substantially different roles when working with adults. Because the sampling strategy sought volunteers across social work adult care teams some of those who came forward had wider roles than I had envisaged, such as team managers, trainers, planners and some were employed by NHS to arrange and manage community care packages as part of community care teams. All those undertaking planning and training roles were, however, directly involved with staff undertaking community care assessments, providing an unintended benefit to the research by broadening the representative nature of the sample. Further research might usefully break down this category further, but the numbers participating in this study were too low to draw significant conclusions based on their roles.

3.5.2 Defining 'Mental Health Officers'

The role of MHO was clarified in the introduction to this thesis and for the purpose of this sample, those regarded as MHOs in this study meet all the criteria described, though seven of the 23 are in promoted posts and the day-to-day work of MHOs varied, even within local authority areas. MHOs have a lead role in seeking and consenting to detention and compulsion under the 2003 Act and reporting on guardianship applications under the 2000 Act, so were a natural group to involve in examining responses to the legislative framework.

3.5.3 Areas selected

In an attempt to understand differential use of the law across Scotland, three different local authority areas were selected. The MWC commented in annual reports on the 2000 and 2003 Acts (MWC 2014a, MWC 2014g), that no pattern is evident. In my own analysis of statistics and personal knowledge, I considered several possible explanations for these differences, including management structures, cultural differences and the urban/rural balance of authorities. I sought therefore to identify a

cross-section based on identifiable statistical differences between the areas, through available literature and from practice experience. The three local authority areas were thus identified, but have been anonymised here for reasons explored in Section 3.4 on Ethics. Some detail is provided here about these identifiable differences to help contextualise participants' comments and to demonstrate the broad range of perspectives encompassed in this research.

Area 1 is a large urban area where social work services had undergone organisational changes, adult services having become very separate from children's services. Statistically the authority had higher usage of mental health legislation relative to other local authority areas. It was slightly above average for rates of STDC and CTOs and significantly below average for use of welfare guardianship (around half the national average). These figures remain fairly constant over time (MWC 2012b, 2010d, 2009a, 2008d, 2007a).

Area 2 is predominantly a rural area although it does include larger towns with many of the urban problems experienced in cities. The area had a single social work department and was a relatively high user of guardianship (the 2000 Act) though this had reduced in 2012 (MWC 2012b, 2009a), possibly related to the introduction of 13ZA in late 2008. At the time of gathering the data older people, learning disability and mental health were all joint services (NHS and local authority), whereby NHS staff carried out broadly similar functions to care managers, holding case responsibility for service users subject to this legislative framework. Area 2 sat above the average rate for CTOs in 2008/9 and slightly below for STDCs. The relevant NHS board also had very high rates of compulsion and detention (MWC

2009a, 2008d). Area 2 had one of the highest rates of banning orders in the last national analysis (Ekosgen 2013), but the numbers were too small to be statistically significant. Apart from the demographics, this area was selected because it was the authority in which I worked, so I was very aware of the structural differences between this and the other two areas and it was clearly convenient for me to access. The implications of my position in this authority have been discussed in the introduction and at several points in this Chapter.

Area 3, an authority, with an urban/rural mix, was amongst the first to develop vulnerable adult procedures after the Border's Inquiry (SWSI 2004). The authority operated as a pilot project for the 2007 Act and actively contributed to research about implementation of the Act. The area consistently reported higher levels of welfare guardianship, both private and local authority, than national averages. Rates of STDC and CTOs were also considerably higher than the local authority average and contribute to high overall usage figures for the local Health Board (MWC 2012b, 2010d, 2009a, 2008d, 2007a). Structurally the social work department was split and community care was integrated with housing.

3.5.4 Recruiting the sample group

The local authorities concerned agreed to distribute information sheets (see Appendix 2) widely amongst adult care staff. Given the cross-section of respondents it appears this distribution was quite widespread and all participants who volunteered were accepted. Of the 48 participants, 41 were employed by social work and seven by NHS. Eleven of these participants were nursing qualified and the remaining 37 were social workers, of whom 23 were MHOs. Of the overall sample 35 were female

and 13 male. Appendix 5 provides a detailed breakdown of the sample group. Figure 1 on the next page shows the user groups with whom participants worked.

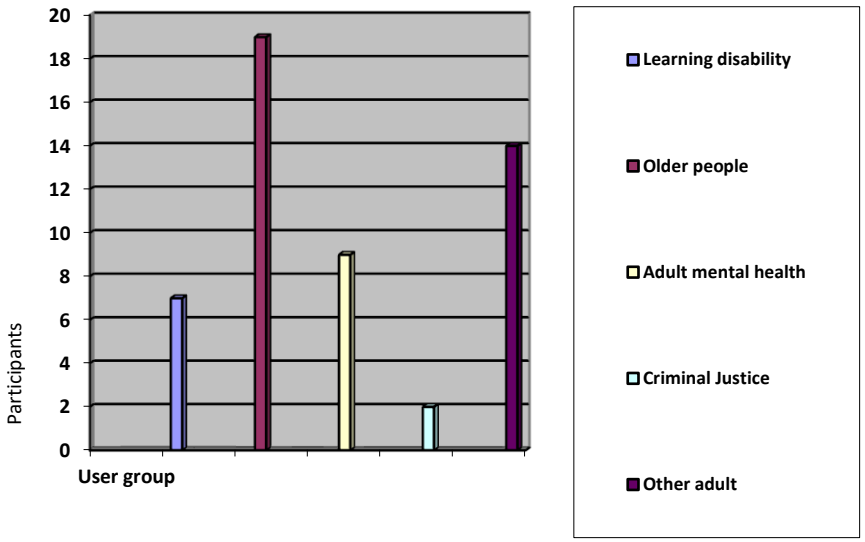

Figure 1: User groups across all areas studied

The sample was a non-probability, purposive or theoretical sample, the preferred sampling method when undertaking qualitative research (Alston and Bowles 2003). The Area 2 group was as an accidental, albeit very relevant sample, in that the participants were convenient for the researcher to target. The groups identified as care managers or MHOs, were people who should have day-to-day knowledge of the topic under study. Barbour (2008) suggests there is little difference between a purposive or theoretical sample, as both are underpinned by a similar theoretical perspective. The theoretical perspective was arrived at in this case from prior knowledge of the topic under examination, statistical evidence, the accountability of local authority staff built into the legislative framework and research about use of the Acts.

As in any non-probability sample the group cannot be seen as representative however, an attempt was made to achieve some degree of stratification by means of ‘quota sampling’ (Alston and Bowles 2003). Purposive stratification as envisaged by Huberman and Miles (1994 in Punch 2014) provides a more balanced perspective. In this case I used a conscious stratification approach in separating out MHOs and care managers, but other elements of stratification, such as status in the organisation and experience arose from the self-selecting nature of the sample. The principal assumptions about these two groups were that it was likely MHOs would be more knowledgeable about law than care managers, and they in turn would be more knowledgeable about the law as it applied to specific user groups, because of their professional role. For example, care managers might have more detailed knowledge in relation to the 2000 and 2007 Acts through working with older people or adults with learning disability, but MHOs might be expected to have a broader knowledge of the legal framework arising from their training and their day-to-day role working across the Acts. The analysis does not entirely bear out this distinction, but as a starting point it proved effective. I planned to run three focus groups in each area, one of MHOs alone, one of care managers alone and the other a mix of the two. Whilst there may be merit in comparing the perspectives of these different professional groupings, this was not a comparative study. The aim was to maximise the range of perspectives on the legal framework across groups responsible for its implementation within local authorities. This stratification also sought to minimise the influence of one group over another and to see if the combined range of knowledge and experience produced additional insights and depth.

As noted earlier, it was not intended to use a truly representative sample from each area, participants essentially being ‘self-selecting’, but it can nevertheless be seen that the major staff groups involved in the day-to-day administration of the legislative framework are represented, so a degree of stratification was achieved. There is also scope to highlight any differences that may become apparent in processes across the three areas. The sampling grid, (Appendix 5) does highlight the different professional backgrounds of the participants. Gender has been included for information purposes only.

The fact that local authority managers were responsible for distributing the invitations and that participants self-selected may have resulted in some bias, though there were a wide range of reasons why people might have self-selected. Additionally, some managers may not have allowed time for staff to participate or may not have passed on information. The sample group was spread fairly evenly across the adult care groups, though drug and alcohol services were most poorly represented. However, the research predominantly seeks to understand perspectives across these groups in relation to the legislative framework and only in relation to each other’s role, where it impacts on their ability to fulfil their legislative function.

Barbour (2008) notes it is useful to consider those on the margins who might bring differing perspectives. In this case, for example local authority lawyers, training officers or senior managers were people I considered interviewing separately. However, four trainers and seven people with management responsibility put themselves forward for the groups, so this has added depth and diversity to the sample. There would be some benefit in surveying local authority lawyers, though

according to participants, few have much experience of dealing with the Acts and in practice, rather than lead, their role is to support interventions proposed by professional staff within local authority.

3.6 Research tools

3.6.1 The researcher as an instrument

Patten (1999 p1204) reflected on the role of the researcher as an instrument and as discussed earlier, asserted that a researcher neither can nor should supress a particular viewpoint, but instead should be clear what that viewpoint is from the outset, ensuring that the reader is reminded of this at appropriate points. In the introduction I explained my own role and motivation for undertaking this research, noting that within this Methodology section I would address the potential for bias. This sub-section examines potential bias I bring as a research instrument. There are three broad areas which have an impact on my views about this legislative framework. These are my roles MHTS and local authority and my abiding interest in this legislative framework. As a tribunal member I might be seen as defensive of legal process on the grounds that I personally benefit from it. However, the MHTS is only concerned with the 2003 Act so this limits potential for bias, but nevertheless I need to be aware of this when reporting and analysing views in relation to the 2003 Act. As a longstanding local authority employee, an MHO and a planner, my views will be informed by my local authority background and as a person with substantial practice experience and a keen interest, I may place more weight on things I believe to be important. However, due to this keen interest and my employment background I am very open to the explanations that other viewpoints might provide and particularly what informs these alternative views. Given the parameters of this

research, these viewpoints inevitably originate from people closely tied in with the local authority, so my professional background and interest puts me in a unique position to better understand others' perspectives. I have of course moved on from local authority to work in education so the analysis spanned both professional roles. As noted at the outset, other professional's views and those of service users, volunteers and informal carers, could bring quite different perspectives on the legislative framework and this could provide an interesting focus for further research. The purpose of this study however, is to understand how those undertaking local authority functions view the framework and how these perceptionss impact on their use of legislation.

As the researcher I was known to participants from Area 2 and to three participants in the other authorities. I only had line management responsibility for two staff in my own authority. Participants seemed to respond positively to my role in leading the focus group and many of the issues I had been aware of, and a few I had not, arose spontaneously from within the group discussions. I believe my role was primarily facilitative and there was little evidence of people feeling constrained as to what topics could be raised. Within my own authority I had good working relationships with most participants, but I was nevertheless impressed by the unguarded and apparently honest input from staff. I found staff in the other two areas responded equally openly, which on reflection I think was a product of being on common ground with many of the participants in relation to the legislation, as well as reflecting my group-work and facilitation skills.

3.6.2 Selecting the appropriate data-collection tool

Having established that I myself was an instrument in this research I went on to consider the optimum means of gathering the required data. I had initially intended to start with focus groups and to add semi-structured interviews and possibly surveys with key staff in the local authority if necessary. Possible data-collection tools are outlined in the following sections before moving on to the rationale for choosing focus groups.

3.6.2.1 Survey approaches

Survey-type approaches such as questionnaires lend themselves best to quantitative research and would be likely to produce some interesting and 'broad' data, but achieving the required depth would be difficult. Denscombe (2010) asserts that surveys will not help in teasing out complex matters or gaining in-depth insights into personal perspectives of participants and that response rates can be very low. I had considered that as an adjunct to the focus groups a survey might provide some useful quantitative data, but in practice it would have been difficult to target the staff with sufficient knowledge, especially given that many of that group had already come forward for the focus groups.

3.6.2.2 Interviews

Structured interviews were dismissed for similar reasons to the survey approach, in relation to achieving depth and richness. Unstructured interviews too were considered but dismissed on the grounds that the data gathered would be too diverse and would make it difficult to draw broader conclusions (Bryman 2008). Semi-structured interviews were however, considered on the basis that participants would have greater privacy and may share confidences, but even these would not necessarily allow people to think more freely around the issues. The interview situation is potentially quite formal and I was aware that my own power in terms of

positional, knowledge and reputational factors could be reinforced by this approach (Bal et al 2008).

3.6.2.3 Case study

Undertaking complex case studies could bring great depth in terms of the roles social work might play in utilising legislation (Barber 2008), but would need to be augmented by some other approach to effectively address the broader issues under investigation. As an adjunct to other approaches I did not see there would be a great advantage to this approach other than bringing in others' perspective on the role of social work, not a primary aim of this research.

3.7 Focus Groups in context

In contrast to these other approaches, focus groups offered a positive opportunity for me to stand back from the lead role, minimise power and control issues and importantly bring the group dynamic into play. It is nevertheless acknowledged that as researcher I set the agenda and interpret the results, so my influence will always be present. Corbin (2008) notes that focus groups are as much about the nature and product of interactions between individuals, as they are about direct answers to questions. In these groups the individuals are professionals who are closely engaged in delivering this framework from a local authority perspective, so these interactions are potentially very informative. Given my background in the field I was very well placed to understand and respond to the subtleties of the ideas expressed. Stopher (2010) suggests that group moderators need to have keen group-work skills to effectively engage and manage the group process. I brought considerable group-work skills from my early social work career, along with an ability to facilitate group interactions, acquired through my long-standing interest in designing and providing

training throughout my social work career. I was particularly keen to bring in the group dynamic because I believed that group members' input would stimulate ideas and reactions from other group members in a way which could not be achieved within individual interviews.

My professional background potentially made me a very visible 'insider' (Corbin 2008), which could unduly influence responses, to agree or perhaps rebel against perceived expectations, and I was well aware that this can contaminate results. Part of the rationale for using focus groups was to allow me to be somewhat detached from the group discussions, hopefully minimising this potential contamination (Corbin 2008; Stopher 2010).

Stopher (2010) suggested that whilst focus groups were an excellent means of obtaining expert views from specialist groups, difficulties in recruiting truly representative samples by this route mean that these should be part of a wider research strategy involving use of alternative survey techniques. However, as the research process unfolded it became clear that the range and depth of data gathered through the focus groups provided a very substantial body of information. This was achieved, partly through the involvement of a wider range of community care professionals than originally anticipated, and partly through participants' enthusiastic engagement with the process. Most focus groups lasted for nearly two hours. Corbin and Strauss (2008), note that the qualitative data gathered from focus groups can provide deeper understanding of issues faced by practitioners within a multi-agency environment, certainly an important aspect in this study. The benefits of separately interviewing other stakeholders seemed limited in terms of gathering new

perspectives. Furthermore, as previously noted, qualitative research is primarily an interpretive process, albeit some positivist aspects may emerge, so achieving a truly representative sample is neither possible nor necessary (Guest, MacQueen and Namey 2012; Patton 1999;). Taking all this into account I elected to use the focus groups as the only data collection tool for this study.

Whilst the depth and range of data gathered from focus groups has been substantial, it is acknowledged that there are limitations arising from solely using focus groups. For example, participants might not disclose more sensitive issues to a group, where they might do so in an individual interview.

3.7.1 Membership of the focus groups

Three groups were run in Area 1 in late 2009 (November and December) involving sixteen staff all drawn from adult services, of whom eight were MHOs. Only five each of care managers and MHOs were at basic grade, the remainder in promoted posts, including a criminal justice manager, or training and development roles. All groups contained a spread of experience with different user groups and men were well represented across all three.

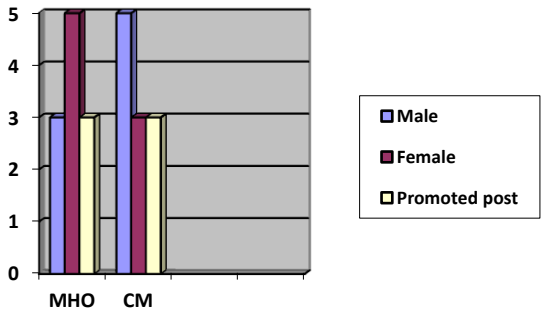

Figure 2: Composition of Area 1 groups

Three groups were run in Area 2 between October 2009 and January 2010. Overall there were 23 participants from across the spectrum of care areas, only two of whom were male and three were in promoted posts. This Area was the only one of the three to employee nurses as care managers. Eleven of the fifteen care managers were nursing qualified, of whom seven were employed by NHS.

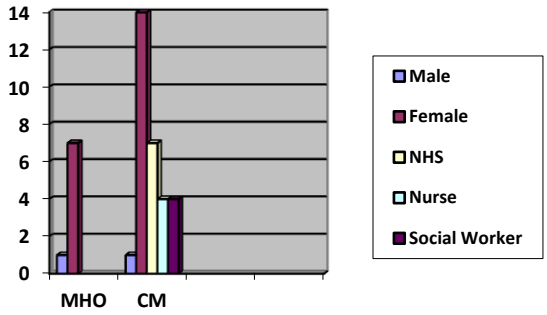

Figure 3: Composition of Area 2 groups

It was only possible to run two groups in Area 3, which took place in November and December 2009, involving nine participants. All participants were social workers, of whom two were trainers and one a manager, six were female and three male. The two trainers, although MHO qualified did not practice as such, so were included in the care manager group. The main adult user groups were represented and two of the MHOs worked with the local NHS forensic unit. According to one manager, because they had recently been involved in quite intensive research around adult protection and had busy caseloads, staff were reluctant to volunteer for further research.

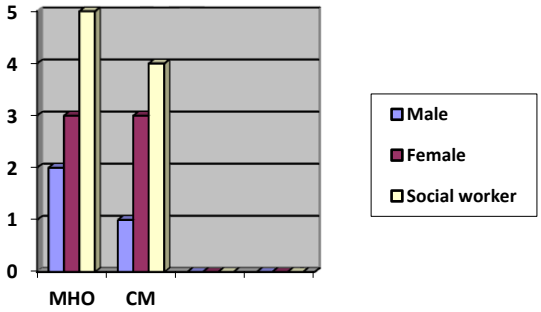

Figure 4: Composition of Area 3 Groups

3.7.2 Operation of Focus groups

The focus groups were structured around some general questions and three case studies (see Appendix 4) which highlighted issues around the three Acts, in relation to mental health, learning disability and older people and also raised the issue of criminal activity and responsibility. Bowling (2009) viewed vignettes (small case studies) as an ideal means to gain information on knowledge, perspective and opinions. Patton (1999) suggests that using purposive samples, such as in this study, should aim to enlighten and illuminate and that focussing on cases can provide great depth, albeit the ability to generalise is limited. The case studies were newly devised for the purpose of this research and were focused on the key research questions and aims and objectives. I was very experienced in adapting actual cases into case studies for training purposes, so I was confident these general scenarios would be familiar to practitioners. I consciously avoided over-complicating the scenarios as I wanted to include questions exploring broader perspectives from practice, not just specific responses to the case studies. I sought to foster debate in relation to participants' perspective of actual 'custom and practice' in implementing the law and to bring spontaneity and a practice focus to the discussions (Frankland and Bloor 2001, Patton 1999). All focus groups were run utilising a focus group schedule (Williman 2006). Broad semi-structured questions were included, exploring

issues which became apparent in the literature review and had come to my attention as a practitioner. These related to risk management, training and effectiveness of the legislation and the session closed with an invitation for participants to express views on the overall legislative framework. Additionally, the groups were presented with the three case scenarios and asked in each case to consider: specific risks; relevance and utility of the legislative framework (including criminal procedures for Drew); any other relevant legislation and any factors that might help or hinder use of law. This approach helped to focus the discussion on the research goals and ensure consistency across the groups.

Focus groups, following this structure, with this group of participants, had the potential to get very close to the decision-makers who underpin this framework, seeking to benefit from what Dey (1993, in Corbin and Strauss 2008 p33) describes as “data sensitivity”. As Dey (ibid) puts it “the issue is not whether to use existing knowledge but how”, emphasising that data may be enhanced by the professional experience of participants. The ethnographic style, discussed in relation to the conceptual framework of this study, is reflected in this approach, whereby I was working with similarly qualified peers to recognise and resolve issues relating to this legislative framework (Guest, MacQueen and Namey 2012).

From a phenomenological perspective, I was trying to gain an understanding of the actual experience of participants in using the framework (Barbour 2008) rather than encouraging them to debate the purpose of it. This more specific data could tell me about their experience in operating the legislative framework and their role in it.

Nevertheless, participants were quick to identify ethical, philosophical and legal debates around the framework, which I did not discourage.

I endeavoured to manage the group processes as equitably as possible across the groups with a view to improving consistency, thereby improving the reliability of comparisons and conclusions. Aware of the potential for influencing the views of participants I consciously monitored my language throughout, to ensure any questions were not leading and that any information I provided to aid discussion was clearly stated, factual and not opinion. Wherever possible the groups were encouraged to discuss the issues amongst themselves without my intervention.

3.8 Pilot study

A formal pilot study was not undertaken, mainly because I believed that this might lead to the loss of valuable participants in the actual research, whereby busy staff would struggle to find the time to take part in the substantive research. This was borne out by experience in Area 3 where, as already noted, it was only possible to bring two groups together. Additionally, I was closely involved in the implementation and delivery of this legislative framework and routinely ran training sessions to staff groups in Area 2 around these issues. This experience contributed to my belief that a small group approach based on case studies would produce debate and discussion, such as was required to take forward this research proposal and that there would be no added benefit from undertaking a pilot study.

3.9 Recording of data

Data from the focus groups was gathered by means of digital recordings, which allowed me to then transcribe these and analyse the results in detail. Alongside the transcripts of the data I kept notes about each session, to remind me about attitudinal aspects, not apparent in the transcript, for example tone of voice, use of humour and general demeanour of the groups. The transcripts were taken from approximately 14 hours of recordings of the eight focus groups between 2009 and 2010 amounting to almost 125,000 words. The transcripts were not confirmed by participants but were transcribed verbatim onto password protected word documents stored on my home computer.

3.10 Secondary data

As noted earlier some quantitative data was gathered from national sources including the MWC, OPG and the Information Services Division of Scotland. Statistics are provided in relation to usage of legislation, the groups affected by legislation and the involvement of family and other carers. This helped to contextualise the qualitative data and to raise issues within the focus groups around differing practices between authorities.

3.11 Presentation of the results and analysis

In setting out the results, referred to here as ‘findings’, I identified a very broad range of views from participants and recorded these as quotes in the text to allow the reader to get a strong sense of the voice of participants. Around 50 sub-themes or codes were apparent, out of which eight broad themes were identified to attempt to

bring coherence to this wide-ranging data. There are a range of approaches to representing findings in qualitative research, most of which suggest that these should be integrated into the discussion (Barbour 2008; Alston and Bowles 2003);. Rather than taking a fully integrated approach I decided to use an aligned approach whereby the discussion immediately follows the record of findings and is set out under the eight broad themes. This approach enables the reader to make immediate connections between the findings and the discussion in relation to each theme as it is reported, minimising the need for complex cross referencing, which helps to 'tell the story' about the actual data (Guest, MacQueen and Namey 2012). Additionally, in attempting to deal with potential perceptions of bias, setting out the findings separately allows readers to draw their own conclusions about the range of views expressed by participants.

I have been wary of overstating the quantitative element, particularly as in focus groups participants may nod in agreement or remain silent, rather than argue a point, so it will not always be possible to be clear about numbers. Guest, MacQueen and Namey (2012) have produced an interesting matrix which balances qualitative and quantitative methods to aid data analysis. In terms of this matrix the empirical data in this thesis is primarily qualitative in nature. The limited quantitative data that is considered, from government statistics and other literature sources, is examined from a qualitative perspective by identifying patterns, rather than a more quantitative approach based on statistical mathematical analysis. Patton (1999) emphasised the need for caution in using quantitative data gathered through qualitative research and made the point that it is not so much being against the use of numbers but more about being "pro-meaningfulness" (Patton 1999 p1207). I have therefore made only

limited comments with regard to majority or minority views from the focus groups, though apparently unique or universally agreed viewpoints are noted, where that may prove useful.

3.12 Analysing the Data

This study seeks to establish how the legislative framework, translates into everyday practice from practitioners' perspective, the 'macro' into the 'micro' as Barbour (2008) put it. Corbin (2008) asserts that this is an artificial distinction and that to gain a full picture the researcher must be aware of both. In this case the micro can be viewed as how the participants perceive and operate the legislative framework, and the macro relates to how policy makers, legislators and senior managers influence the context in which they work, in terms of resources and policy objectives. In this research I believe the micro-analysis is essential to gain a better understanding of the concepts and terms as used by participants (Corbin and Strauss 2008). The macro view will be addressed in the analysis through a synthesis of the literature accessed and the perceptions of participants. The links to literature help to demonstrate the relevance of identified themes to the wider public debate.

3.12.1 Approaches to Data Management

Inevitably with 125,000 words of transcript there was repetition so it was necessary to use a systematic approach to extract useful data. I considered using N – Vivo, but rejected this in favour of manual approaches as the danger of missing important nuances within the data had to be considered. Guest, MacQueen and Namey (2012) illustrate this point in relation to research examining stigma, whereby computerised systems might not recognise other words participants use to describe the

experience. Similarly, within this research, in relation to ‘deprivation of liberty’, participants often describe the phenomenon without using the actual term. Patton (1999 p1205) synthesises the issues thus: “A qualitative analyst returns to the data over and over again to see if the constructs, categories, explanations, and interpretations make sense, if they really reflect the nature of the phenomena. Creativity, intellectual rigor, perseverance, insight - these are the intangibles that go beyond the routine application of scientific procedures”.

3.12.2 Process of Analysis

The data analysis is based on a flexible approach, utilising differing approaches to analysing data from the focus groups and that gathered from other sources. In this regard, despite some inconsistencies in reported quantitative data on usage of the Acts and the general limitations associated with using secondary sources, such data was largely descriptive and proved useful in highlighting variable use of the law and information on national trends. The analysis of core data from the focus groups was undertaken utilising a ‘thematic approach’ (Guest, MacQueen and Namey 2012; Braun and Clarke 2006) though Corbin and Strauss (2008) highlight the benefit of mixed approaches to interrogating data. Responses were initially reviewed to develop a coding system, which was then applied and revised several times as themes began to emerge. This thesis focuses on perceptions of practitioners about the legislative framework and was thereby best suited to the analyst using “sensitising questions” when reflecting on the data (Corbin and Strauss 2008 p72). This approach seeks to gain an understanding of what is happening, reflecting the earlier noted emphasis on phenomenological and ethnographic dynamics (Guest, MacQueen and Namey 2012).

I used an element of ‘content analysis’ (Bryman 2008), whereby I tried to identify the frequency and range of metaphors used and gain some quantifiable understanding about the strength of feeling that arose around particular issues. This process was by no means ‘scientific’ but did influence the development of coding and ultimately themes. Corbin (2008) suggested use of a ‘flip-flop’ approach when trying to understand such metaphors, for example, in this case some described the legal framework as ‘toothless’, so I had to consider what it would mean if the framework had teeth. Finding contradictory views within the data can also help to clarify the important elements of the dominant viewpoint. However, it is important to emphasise that this “content analysis” which (Guest, MacQueen and Namey 2012 p9) describe as a “an object for analysis” was not prioritised over analysis of text (which they describe as “a proxy for experience”) as this understanding of participants’ experience was a core purpose of this analysis.

A form of colour coding was used, informed by Corbin and Strauss’s (2008, 1997) ideas about constant comparative analysis, whereby codes (elements of participants’ experience) were identified, revisited and reviewed until an effective definition of the points being made was established. It was difficult to infer much from these initial descriptive, topic codes but the emerging themes were more interpretive in nature, drawing out patterns which were open to analysis. Richards 2005 (in Punch 2014) described this as a linear process, moving from descriptive ideas to topical themes to analysis. For example, I identified a range of ‘codes’ across the groups which reflected attitudes, processes and thresholds around risk, others’ views on risk and aspects of professional judgement, mainly grouped under the ‘Risk’ theme. However, some similar data was more closely linked to issues around management and policy

which were variously included under themes of ‘Use of legislation’ and ‘Bureaucracy’. These themes were therefore neither preconceived, nor arbitrary but arose from the data, arguably, to some extent reflecting key elements of grounded theory (Barbour 2008).

A further element of grounded theory in this analysis becomes apparent when the data begins to present some interesting and perhaps unexpected perspectives. These are used to put forward some theories, particularly around the differing uses of the legislative framework across different authorities. For example the sources of knowledge identified by most participants were, perhaps surprisingly, trusted colleagues, rather than text books, training courses or organisations which provide advice.

It was evident that data gained from focus groups could not be easily categorised and therefore careful interpretation would be needed. Barbour (2008) argues that the core belief about grounded theory, that it is possible to analyse and gather data without any preconceived ideas, is rarely either possible or desirable. In this case I had identified what I believed were important questions to address around the legislative framework and both the sampling and data collection techniques sought to answer these questions, not just explore the issue in a general sense. As Corbin and Strauss (2008) noted even descriptive analysis brings in the researcher’s perspective, in deciding what to describe or select from the data. I needed to be very wary of seeking a specific, pre-conceived set of answers, rather than keeping an open mind to other narratives which might be present. This openness to other possibilities can be related to principles of ‘grounded theory’.

3.12.3 The influence of researcher positionality

Tufford and Newman (2010) note the strong potential for the reflective element of bracketing to help bring objectivity, clarity and depth to the analysis stage in qualitative research. This suggests there are clear advantages to people with expertise undertaking research into complex specialist areas. My personal and professional interest is therefore not something to be avoided, as my own perspective has been an important factor in undertaking this research, helping to shed light on, what is at times, a confusing picture. Indeed, a high degree of knowledge in the field potentially trains the eye to look for subtle differences in meaning. This was certainly the case when analysing this data as I was very familiar with the issues participants were raising. Being mindful of the dynamic principles of bracketing (Tufford and Newman 2010), I have acknowledged the potential for bias and influence at appropriate points in the course of this analysis (Barbour 2008), yet have brought my expertise to bear in providing an analysis of the findings.

3.13 Limitations

For the sake of completeness this sub-section provides a brief over-view of methodological limitations of this study, cross-referenced back to relevant parts of the methodology chapter to minimise repetition.

3.13.1 Qualitative approaches

As this study is not experimental in nature and has no substantial quantitative element, caution has been exercised when generalising from these findings (Barbour 2008). Given the focus on individual perceptions, more objective analysis of processes is not possible. In any future study focusing on quantifiable outcomes might provide another facet in understanding the legislative framework.

3.13.2 Sampling approaches

The sample, whilst slightly more representative than initially expected, was a self-selecting, purposive sample. This meant that the group were likely to be interested and knowledgeable, but it is possible there were ‘unheard voices’ amongst those who did not come forward. A more randomised approach to sampling might give a broader, more representative picture, though conversely might undermine depth and richness of discussion.

3.13.3 Pilot studies

Section 3.8 outlines reasons for excluding pilot studies but it is acknowledged that with a larger potential sample this would have been beneficial.

3.13.4 Anonymity

The decision to anonymise the authorities concerned, as well as the individuals is discussed in s3.4. Whilst it allowed greater freedom to fully report participants’ viewpoints, it did limit my ability to provide specific figures or make direct comparisons. This might have helped identify reasons for differential use of the framework between authorities, albeit most reasons identified for differential use were not area-specific.

3.13.5 The literature search

There were few research-based papers linked to the legislation itself to some extent limiting the scope of the literature base. As 10 years has elapsed since commencing this study I have attempted to incorporate new literature which has emerged and reflect on its significance. It nevertheless remains the case that few qualitative studies examine the overall framework and none centrally address the local authority role, which underpins this research study.

3.13.6 Sources of data

The decision to only involve those discharging local authority functions might be regarded as a limitation, but the fact that this group's perspectives are under-reported was a unique and central element of this study. Views of psychiatrists, service users and carers would be of particular interest, but these views have been gathered to some extent in other research.

One potential limitation arises when considering the macro and micro dynamics as discussed in s3.12. The micro view is obtained from practitioners, but the macro view would be derived from policy makers and managers (Corbin and Strauss 2008). Several participants had a background in planning or management and it became clear that local authority managers looked to these staff for advice, so the primary data does include elements of the 'macro' view, but this perspective could be broadened.

3.13.7 Focus groups

Limitations arising from using focus groups were fully rehearsed in s3.7, but it is worth adding that the focus on case studies and informal nature of the group processes aided participation and participants responded to and expanded on examples given by other group members. Participants' seemed well able to challenge each other and I made full use of group-work skills to manage group processes and maximise participation. The anonymity of questionnaires or the privacy of interviews potentially provides quantitative data as well as fresh insights. However, this study did not seek to quantify data and already collected wide-ranging qualitative data, so this was not a major detriment. Nevertheless, other data collection methods could be considered in future research.

3.14 Concluding remarks

This account of the methodological approach reflects on important elements underpinning the overall approach to this thesis. As noted I have adopted an iterative approach informed by, ongoing reading as new material about the framework has emerged and reflection on my own positionality in relation to this research. I have also had to make significant revisions, following the viva. Given that this thesis has been completed over a ten-year period I have endeavoured to approach this in a consistent manner and have always been mindful of the impact that changes in one part may have on other elements of the thesis. This has necessitated keeping in mind a broad overview of the aims and objectives and ensuring that these have been fully reflected throughout the thesis. To this end I have taken every opportunity to present updates on my research to student and staff groups throughout this period and as noted earlier have made use of supervision and extensive notes. Issues about the framework, positive and negative have become apparent as the law has been tested out in tribunals and courts and I believe that the important issues explored in this thesis continue to have relevance and vindicate the methodological approach adopted here.

The following Chapter presents the findings and discussion across the thematic headings and sets these in the context of the current situation. Direct links are made to the aims and objectives and associated research questions, providing considerable insight into practitioners' views about this legislative framework.

Chapter 4

Findings and Discussion

4.0 FINDINGS AND DISCUSSION

4.1 Introduction

Before examining the data used to inform this study it is worth briefly reflecting on the principal purpose of this study as expressed in the research title:

A qualitative study examining the Scottish legislative framework dealing with mental health, incapacity and adults at risk of harm, from the perspective of professional staff undertaking related social work functions

It is clear from the available literature that there are wide local variations in use of the legislative framework and that, despite the fact that there are many new measures under the framework, the key roles relating to NHS and social work remain largely similar, likewise outcomes in terms of compulsion and detention. This thesis seeks to establish the views of one key group of stakeholders, namely those carrying out social work functions. It is intended that this will provide insight into the broad issues for practitioners, help establish needs for training, advice and guidance and identify any emerging areas of concern about the framework itself. As noted in the introduction the two aims identified in this thesis relate to understanding the credibility of the legal framework from the perspective of participants and how these professionals interpret the law. The themes outlined in this section reflect the range of views expressed by participants, many of which reflect policy objectives as well as information identified in reports, inquiries and other research documents.

4.1.1 The structure of this Chapter

The themes, as noted in the methodology section, were identified by means of thematic analysis (Guest, MacQueen and Namey 2012; Barbour 2008; Corbin 2008). Eight broad themes were arrived at, with various sub-themes based on the initial codes identified. Before embarking on what is inevitably a lengthy section, it is worth clarifying some issues around the structure. For ease of reference the findings under each theme, are immediately followed by discussion of that theme. The findings represent a summarised account of participants' views and make wide use of quotes to enable the reader, in as much as it is possible, to draw their own conclusions as to the perspective of participants. The discussion sections which follow incorporate comprehensive analysis of these findings, based on the research aims and objectives and material cited in the introductory sections and review of literature. There are eight thematic headings, under each of which are two main sub-sections headed 'findings' and 'discussion'. Chapter 5 draws out the principal conclusions and recommendations arising from these discussion elements.

The following table outlines how the codes and themes were arrived at, highlighting links to the aims and objectives of the research and to the review of literature.

Table 1: Themes and sub-themes

Main theme	Sub-themes/Codes
Theme 1: Knowledge of the legislative framework	Training received Sources of advice Ability to identify the correct legislation
Theme 2: Use of the Acts	Relevance and utility for participants' roles Experience of using the framework Role of other professionals Views on coherence across the three Acts Compatibility with other legal powers and duties
Theme 3: Risk issues	Interaction between law and risk management processes Impact of risk thresholds Inter-agency issues relating to risk Nature of risk identified by participants
Theme 4: Involvement of carers	Conflict between carers and service users or professionals Supporting and involving carers in planning and delivering care Protection issues
Theme 5: Diagnosis, assessment and consent to treatment	Responsibility for assessment Ethical dilemmas Information sharing Interagency working Impact of other factors such as substance misuse or physical disability
Theme 6: Bureaucracy	Resources Service demands Professional autonomy Management role Accountability Processes
Theme 7: Human Rights	Use of restraint Deprivation of liberty Right to treatment Criminal proceedings Stigma Lifestyle choice versus need for protection
Theme 8: Attitudes to the legislative framework	Participants' perceptions of framework expressed spontaneously or in response to direct questions

4.2 Introducing the primary data analysis

It is important to ensure the findings are set in context, so there follows a brief reminder of the constitution of the focus groups, the participants' professional roles and an overview of the case studies and questions. Corbin (2008) emphasised that a symbolic interactionist perspective was important when undertaking qualitative research, in that the setting and the norms that workers experience will affect their perception of the issues. There were differing perspectives, for example, between geographical areas and professional groupings, so where relevant these wider perspectives are acknowledged to help interpret the data.

4.2.1 Attribution of quotes

Where quotes are provided the participant will be referred to as either care manager (CM) or MHO and given a number which corresponds to the list in Appendix 5. As explained in the methodology section, participants labelled CM will have a role as an adult care professional but not as a practising MHO. Where labelled 'MHO' the worker will be a practising MHO but may also perform other functions, such as planner.

4.2.2 The case studies

The full versions of case studies are in Appendix 4. A brief summary is provided below and these will be referred to by name (for example 'the Victor case study …') throughout the findings and discussion section.

4.2.2.1 Victor

An older man admitted to hospital following concerns about advancing dementia, for whom key people, including his son, believe nursing home care is required.

4.2.2.2 Harvey

A 40 year old man with learning disability, living with his parents is subject to limitations on his freedom by his parents. They do not wish him to take up a day centre place. They currently crush up his anti-epileptic medicine and put it in his porridge. He inherited a fairly large sum of money and may be subject to financial exploitation from local people known to exploit others.

4.2.2.3 Drew

This man, with bi-polar illness, sent a threatening note, along with a dead bird to a care worker. Having been arrested, not for the first time, for possession of a knife, consideration is being given to possible charges and future action.

4.2.3 Overall findings and analysis of the focus groups

The remainder of this Chapter is set out under the thematic headings. The Findings sections include extensive quotes some of which are in direct response to questions within the focus group schedule, others are unprompted and arise from group discussions. All quotes are parenthesised, but only lengthier quotes are attributed to specific participants. As already noted, some issues are ‘cross-cutting’ in that they straddle two or more themes and where appropriate this is highlighted

4.3 Theme One: Knowledge of legislative framework

4.3.1 Introduction

The discussion on emerging data from this theme helps shed light on how well-prepared staff feel to use legislation, from where they receive support and guidance and to some extent explores the range of their knowledge across the framework. The discussion will partly address the second aim in relation to how participants interpret

the law but may also provide some answers as to the credibility of the legal framework from participants' perspective. Reasons for local variation in use of the law and in what circumstances it is seen to be most useful will also be discussed where relevant.

4.3.2 Findings

The findings linked to this theme are grouped under headings related to the component codes of training, advice and knowledge of the legislative framework.

4.3.2.1 Training

Participants across the groups were quick to raise concerns about training in relation to the 2007 Act. Several stated that the training came too early, before the processes were properly in place. Interestingly, the most structured training was in Area 1 where Council Officers were required to undertake specific training, up to Levels 3 of 4, yet there was considerable confusion amongst these participants as to who was meant to attend what training. It was reported that some council officers had been accredited under previous processes, which did not stipulate achieving Level 3, and many were critical about the basic nature of Levels 1 and 2. Participants noted this training arose following an inquiry which identified serious shortfalls in adult protection processes and training. Despite assertions by a development officer CM16, that there was an integrated approach to training across the Acts, many others in that group disagreed. With regards to other training in Area 1, training for the 2000 Act was to be developed the following year and risk training provided for MHOs was seen as unhelpful by several who commented.

There was apparent unanimity across all areas that 2007 Act training was not applied to practice, so participants struggled to operationalise their learning. MHO18

commented that “the operational instructions, the whole Act were not in place. We were dealing with something fairly nebulous”. Area 3 training staff confirmed there were no operational instructions for any of the Acts in their area, on the basis that the codes of practice contained sufficient guidance. For some in Areas 2 and 3 the training was seen as “procedurally” rather than “practically” focused. One Area 2 MHO commented that the training focused on “bread and butter” cases which did not help staff to understand what needed to change, CM24 observing that “you need something to hang it on”. Feedback about training on the 2000 and 2003 Acts was more positive, from those who had benefitted from it. However, many said little or no training was provided, further to that made available when the Acts were implemented. An Area 2 MHO expressed concern that the training “compartmentalised” the three Acts making it difficult to get an overview of the framework. The issue of capacity surfaced frequently and is reported under several themes. One Area 3 MHO felt strongly that training on assessing capacity should be available. The Area 3 training strategy differed from other areas, in that each Act had its own training officer, yet like the other areas it seemed 2007 Act training had been prioritised to the exclusion of the other Acts.

Although all three areas had provided risk training developed by the Scottish Government for MHOs, in relation to MDOs and the revised MOP (Scottish Government 2010e), several MHO participants had not been invited to take part. No care management staff reported receiving risk training.

Area 1 CM group members reported that other professionals have had very little training on the framework. A planning officer in Area 1 noted that there were a ‘lot of

players involved (in the 2007 Act), but the quality of joint training is very poor' (CM14). This was backed up in Area 2 where NHS staff reported having had little or no training on any of the Acts.

4.3.2.2 Advice

Areas 1 and 2 had both appointed an experienced MHO qualified practitioner (myself in Area 2) early in the implementation stages of the 2000 Act, whose role involved advising, training and devising policy. Many Area 1 and 2 participants advised they routinely turned to these officers for advice, regarding them as having expert knowledge in the legislative framework. This person was variously described as the "in-house expert" (CM Area 1), "local expert" (CM Area 2) "the council's goddess" (CM Area 1) or "guru" (CM Area 2). Although the roles no longer existed in these areas because of recent staffing changes, participants across all three areas reported that many local authorities had made similar appointments. CM14 in Area 1 commented that when the previous "expert" had been in post it was "a bit of a rallying cry just phone NAME" (CM14). Similarly, in Area 2 a Community Learning Disability Nurse (CLDN) commented that when seeking help to "place things together", she and her colleagues would call the "expert", "just phone NAME and he'll tell you which piece of legislation to use" (CM34).

In Area 3 some participants saw the three aforementioned training officers as "experts", though there was debate as to whether it was competent for them to offer advice. The lead for the 2000 Act commented that "if X (the lead for the 2007 Act) was giving advice to a social worker that was different to the advice given by a team leader or service manager ...that could get really difficult".

In all areas there seemed to be an informal, hierarchical approach to seeking advice. All three areas operated MHO duty rotas, which were often used as a first-line source of guidance. The 'experts' were closely involved in supporting MHO services so many participants reported this to be their first port of call. For several others contact was made with the 'expert', or the duty MHO, following consultation with peers, experienced in particular interventions or who had "appropriate knowledge". A few CMs utilised formal line management arrangements for advice, but MHOs tended to use peers unless they were managed by another MHO. Although more senior levels of management were used to sign off decisions, no-one reported using them as a source of advice.

Following on from this, the route to seeking advice varied. Areas 1 and 3 in particular were very reluctant to approach local authority lawyers (the legal section), who were seen as "not well informed" (MHO9). CM48 commented that following the departure of a trusted solicitor from their legal section that "the lawyers who stood in haven't a scooby about these matters". An Area 3 MHO reported using the legal section to validate their thinking "better to confirm, but discuss issues with colleagues first" (MHO42). Several CMs from Area 1 burst out laughing at the suggestion that advice might be sought from their legal section, one describing them as actively obstructive and uncommunicative. Area 2 was a little more positive, noting that their lawyers offered practical assistance preparing 2000 Act applications. Area 1 lawyers reportedly acted independently to seek 2007 Act banning orders, prompted by, but not directly involving, community care staff. This apparently related to attitudes of local sheriffs, who employed a very strict interpretation of the rules relating to application processes. NHS staff who commented, did not approach their own

Central Legal Office for advice, though the numbers were small and all were at basic grade level.

The next stage in this emerging hierarchy of advice involved regulatory bodies, the two most frequently mentioned being the OPG and MWC. The OPG, cited less often, was generally regarded fairly positively, though as one Area 3 MHO noted this advice was more about “process” than “people”. Two of his colleagues (MHO and CM) were less convinced that even the advice on process was helpful. The MWC on the other hand was mentioned by nearly every participant and few had anything positive to say about the quality of advice they gave or the role that they played. Most saw the MWC as a last resort for advice (strongly stated by MHOs Areas 1 and 3), often contact being made, simply so case records could demonstrate that the MWC had been consulted. In Area 3, MHO 46 commented that the quality of advice from both the OPG and the MWC is “so variable” as to be “worrying”. The variability of advice from regulators and legal sections was echoed in Area 1 “how can I be diplomatic about this ...it is a bit of a lottery ... who you get at the MWC … at the OPG or in our legal department... different person, different answer so why bother” (MHO2). MHO3 agreed noting that in their routine responses they “don’t know any more than we do”. In Area 2 CM23 asserted that “If you go to the MWC for help they will often sit on the fence, they want you to make the decision” and CM24 added that “they (MWC) only get involved if there is something wrong”. On a more positive note MHO8 stated that she might approach the MWC or OPG for clarification, but would be more likely to approach a local person “with knowledge” for advice. Another MHO from Area 3 stated he would quite often phone MHTS or MWC to “check something out”

A few participants across different areas cited more individual ways of getting advice. Area 1 MHOs accessed Codes of Practice for guidance and made use of supervision, though interestingly, contrary to MHO standards (Scottish Executive 2005b), only MHOs in the full-time teams in Area 1 received supervision. Area 1 MHOs also highlighted that if you could find someone that "knows their stuff" that was helpful, acknowledging that might be in the MWC or their legal section. The Area 1 CM group members' non-verbal responses suggested scepticism about the Development Officer's (CM14) claims that the council website contained everything you needed to know ("it is all spelt out there") about the process of dealing with someone at risk. Area 2 participants, principally the care manager group, referred to the utility of briefing papers circulated by management and use of the internet to research aspects of the Acts. An NHS staff member referred to getting advice from psychiatrists, as did an MHO in Area 1. Though in contrast, members of the MHO and care management groups in Area 2 reported having to advise psychiatrists because they had no meaningful training and were so out of touch with the framework, particularly around assessing capacity. In Area 3 positive relations with private solicitors perceived to have expertise in the 2000 Act were seen as helpful by a few MHOs.

In summary, there was an overwhelming feeling expressed by all participants that access to reliable advice was limited. There was almost universal discontent with support from the regulators, particularly the MWC, and few positive comments about local authority legal sections. The sense was that advice was very much sought and that local experts and experienced MHOs were viewed very positively. Two perspectives not widely reflected across the group nevertheless seemed important.

CM24 in Area 2, echoed less explicitly by others elsewhere, stated that “who you ask depends on what outcome you want”. The other interesting perspective was the observation by MHO1 in Area 1, that getting advice about written rules is easy enough and is helpful, but the differing interpretation of these rules presents real dilemmas: “already we are discovering that there are big differences within this group (MHOs), within our department... across the country, so society still has to work out what that means given the written rules ... there are people now whose job it is to help us know what the written rules at least are ... some of us never remember”.

4.3.2.3 Knowledge base

An attempt was made to establish the knowledge base of staff in relation to this framework. These findings were mainly derived from the case studies used to stimulate discussion, but responses to questions around training and advice-giving provided a wider context. Further data will be reported on under the theme ‘Use of legislative framework’ as there is some overlap between these two themes.

Looking at ‘the ‘Drew’ case study which focused on criminal procedures, it was apparent that a few MHOs in Area 3 were conversant with criminal procedures aspects of the 2000/2003 Acts, other MHOs were much less familiar with such processes and non-MHOs even less so. In the Area 1 MHO group members highlighted the need to share information on ‘Drew’ to avoid simplistic conclusions about his behaviour. In response to this, demonstrating awareness of MWC and other inquiries, MHO5 noted that “high levels of tolerance within a community lead to tragic consequences”,

In Area 2 care managers in teams for older people and learning disability reported they were less familiar with the 2003 Act, whilst NHS staff in the community mental health teams reported less familiarity with the 2000 Act, but MHOs generally seemed conversant with both. A care manager (CM22) reported that when challenged by a Sheriff to change elements of the guardianship application she was leading, neither she nor the accompanying legal advisor had any idea how to proceed. A CLDN on the other hand was able to articulate a clear understanding of the fact that intervention under the 2000 Act did not necessitate undue restriction and seemed to have a good grasp of how the powers operate.

MHOs in Area 3 believed that medical staff were poorly acquainted with reviewing and renewing orders, and with recall processes from Community based CTOs, leading to overuse of emergency detention or STDC. Medical ethics arose in Harvey's case as his medication was being administered covertly. MHO1 reported that he remembered "…a huge report came out last year, hundreds of pages long I didn't finish it…all about covert medication". Knowledge of law underpinning such arrangements amongst participants varied, though a couple of situations were described by Area 3 MHOs where the MWC had been approached to endorse a "covert medication" regime, but had refused consent. MHO5 acknowledged having only a vague understanding of whether s47 of the 2000 Act could support this approach.

CM11 in Area 1 reported being able to distinguish between the different Acts to some extent, but that her knowledge was limited, later stating: "I'm hopeless with AWI especially finance". Awareness of Part 3 of the 2000 Act, which enables proxies

to manage day-to-day financial arrangements, was limited when discussing possible financial exploitation of Harvey. MHO8, noted that she has been invited to case conferences where guardianship had been agreed, prior to her involvement and she thought “oh my god that is as much like guardianship as flying through the air”. This had resonance for several participants (MHOs and others), and MHO10 added that “the need for guardianship may be clear to the chair but not to us”. From these participants’ perspective it appears that knowledge about the conditions for guardianship in the wider body of social work is limited.

Many participants, both CM amd MHO, incorrectly assumed Continuing Power of Attorney also allowed for welfare interventions. Area 1 MHOs demonstrated least knowledge of these processes, perhaps because they did not work in older people’s services, where these are predominantly utilised. Few participants were able to make the connection between Victor’s case and 13ZA. NHS employees and those employed in adult mental health services, were largely unaware of 13ZA and those who were, had little knowledge of the associated processes.

4.3.3 Discussion

This theme, in line with the second objective of this study, helps reveal how participants interpret the law and also provides insight into how participants’ interpretation of law is influenced. When setting out the rationale, variable application of legislation and the large volume of legislation and guidance were highlighted as possible factors. Anything which sheds light on the first objective relating to credibility of the law from practitioners’ perspective will of course be highlighted. The same headings used to record the findings are used here for ease of reference.

4.3.3.1 Training

Whilst it was clear that across the groups there was an overarching awareness of the framework, detailed knowledge seemed more variable. Knowledge of the 2007 Act seemed greater, perhaps because of the high profile this Act has achieved and the fact that the focus groups took place shortly after implementation and associated induction training. Changes in personnel and structure arising directly from the Acts, were evident, such as the appointment of training officers for each element of the framework in Area 3. A strategic approach to 2007 Act training was reported in Area 1, where Council Officers were only appointed once they had achieved a required standard. However, this was apparently applied inconsistently, staff were unsure about arrangements for accessing this training and there seemed to be problems prioritising the right staff. Findings from the other two areas were echoed in the national Adult Support and Protection Biennial Report summary (Scottish Government 2011a), which asserts that training strategies are very variable. Many participants from all three areas reported that little training on the 2000 and 2003 Acts had been provided since they were implemented. In Area 1 a development officer claimed these Acts were integrated into Adult Protection training, but it was more widely commented that training seemed to be compartmentalised rather than integrated, as envisaged by Government when developing the legal framework (Scottish Government 2011a). Many participants believed lack of ongoing training, particularly that which helped them link theory to practice, was an obstacle to learning and professional development around this framework. They also echoed Atkinson's (2007) findings where participants in her study felt that training could only go so far and it was practice experience where the real learning happened. Participants cited lack of training on managing risk and on assessing capacity. Although neither are explicitly the duty of local authorities when implementing the

law, such training could contribute to better informed decision-making, and might address concerns around lack of practice focus.

Findings from MWC inquiry reports (MWC 2006b – 2016b), frequently assert that professionals charged with delivering on this agenda are poorly prepared and informed and that there is a need for improved training. This was certainly apparent for those discharging local authority functions in these focus groups between 2009 and 2010. More recent MWC reports note that health and social care professionals misunderstood the need to address deprivation of liberty (MWC 2013c) and failed to address legal capacity (MWC 2016a), suggesting that the situation has not improved.

The Millan Committee (Scottish Executive 2001c) and Scottish Law Commission (1995) reports highlight the confusing array of legislation relating to incapacity and mental health, including repeated amendments and changing guidance, as justification for a full-scale reform of the legislative framework. However, it appears that from the findings of this study and later commentary in MWC inquiries, that, 16 years on from implementation, there is considerable confusion about measures under the 2000 Act and the interface with the 2003 and 2007 Acts, so perhaps the sought after clarification has not been achieved. Caution should be exercised in being too critical however, as Bean (2001) suggests, with some justification, that mental health law is deliberately vague as it is dealing with imprecise aspects of human behaviour. The current president of MHTS echoes this view preferring to see the 2003 Act as “therapeutic” rather than “formal” law (Morrow 2012). Morrow did not see this as a negative, rather he asserts that this different approach needs to be

acknowledged. Studies of the 2007 Act (MacKay et al 2011), and in relation to mental health law more generally (Campbell 2009), offer support to this view, suggesting that over-prescriptive approaches are not helpful.

4.3.3.2 Advice

Analysis of responses quickly highlighted an interesting, hierarchical approach to seeking advice. Briefly summarised people initially went to those in whom they had most trust, usually peers with relevant experience, practising MHOs, or those appointed as local "experts". The order of these three varied slightly, with some describing the expert as the first port of call, where others would have spoken to colleagues and/or MHOs first. The principal reason for this contact seemed to be to acquire knowledge or to discuss ideas. The next stage in the hierarchy related to management, regulators and legal departments, broadly in that order, but again subject to some variation. Less often this was for advice, more often for ratification of decisions, or as a form of defensive practice (Titterton 2005) whereby records could demonstrate responsibility was shared. The OPG role in advice-giving received least attention and responses were mixed as to the level of helpfulness. Managers whilst often seen as helpful were not generally seen as knowledgeable. Surprisingly far from being supportive, local authority legal services were seen by many as unhelpful, sometimes obstructive and a few participants reported having to advise legal colleagues on matters of law. The greatest criticism however, was levelled at the MWC who were, with few exceptions, viewed to be unhelpful, punitive or inconsistent.

Other means of seeking advice, usually in the early stages of intervention, were reported on by small numbers of participants. Two or three participants stated that

they would seek advice from people they expected would tell them what they wanted to hear. This echoed Atkinson's (2007) findings on use of compulsion, that some participants in her study, sought outcomes which they believed the tribunal would find acceptable, rather than truly considering alternatives. Approaches to others, such as psychiatrists or private solicitors were reported by a few. Conversely a few participants reported that psychiatrists, as gatekeepers of the legislation, also turn to MHOs for advice on how the legislation works. This raises concerns about the standards of training and sources of advice for key NHS staff. A few participants reported directly accessing materials such as the codes of practice or operational guidance.

Findings relating to advice raise interesting issues as to how the law is interpreted. The data suggests that, for most participants, guidance on law is not acquired by individual research or training, nor is it sought from lawyers, managers or regulatory bodies. The principal sources of advice for participants were MHOs and appointed experts, who generally had extensive MHO experience. It seems inevitable that this will result in variable advice, depending on the experience and perspective of the MHO or expert and how far those seeking advice actually follow it. Where orders need to be confirmed by courts and tribunals there is clearly a legal process which needs to be satisfied, which brings some consistency to the process. However, evidence of variable application of law across the country, as highlighted in the review of literature and in feedback from participants, suggests even this is not consistent. Additionally, many interventions are not routinely overseen by these bodies (for example s13ZA, s47 medical certificates and Power of Attorney under the

2000 Act). Furthermore, many interventions are informal, that is take place without recourse to this legal framework, so there is no external check on these processes.

One Area 1 MHO participant implied that an industry has developed in providing advice about the 'written rules', but because society has yet to work out what it wants from these laws, practice advice is inconsistent. This very much echoes debate in the literature around balancing responses to criminal procedures, mental health and perceived public pressure (Greig 2002; Bean 2001) or where thresholds for compulsion should be set (Patrick 2008; Atkinson 2006; Killeen et al 2004).

4.3.3.3 Knowledge base

The findings suggest knowledge of the Acts, amongst the staff group charged with using them, is patchy at best. Different disciplines make more use of one part of the framework than others, for example older people and learning disability staff seemed familiar with the 2000 and 2007 Acts, where the CMHTs were more familiar with the 2003 Act. Many MHOs were concerned that decision-makers at case conferences had no idea about the criteria for guardianship under the 2000 Act and often found themselves having to persuade other professionals to backtrack from clearly inappropriate use of guardianship. It should be noted that 13ZA, although much anticipated was only introduced in March 2007 so was still relatively new when the focus groups were conducted, perhaps explaining limited knowledge of this measure, particularly notable in Area 1.

The 'cohort study' into the 2003 Act (Dawson et al 2009a) posited that the overlap of the 2000 and 2003 Acts was poorly understood by professionals, and that this could only get worse following implementation of the 2007 Act, a phenomenon very much

recognised by participants in this study. Cognisant of this even before the 2003 and 2007 Acts were implemented Killeen et al (2004) had questioned whether the 2000 Act would benefit from simplification. Furthermore, they suggest that knowledge around Powers of Attorney is very limited across the board, citing complex processes and low public awareness, still an issue according to findings from the focus groups. Gordon (2004) identifies confusion over use of investigative powers under the 2000 and 2003 Acts and related duties of regulators and local authorities. Confusion amongst participants and complex case examples cited by them indicate that these early commentaries were identifying real practice concerns. Perhaps because of this complexity measures remain open to interpretation at the highest levels. Commentators such as Patrick (2008), Ward (2007) and Sheriff Court decisions (Scottish Courts 2013, 2007, 2004), cited in the literature review, highlight significant disagreement over the criteria for use of Guardianship under the 2000 Act. Patrick (2008) in particular goes much further in questioning the whole basis of the 2000 and 2003 Acts, as to how far these Acts can authorise deprivation of liberty.

4.3.3.4 Summary

Overall then, this theme of knowledge, has encompassed training, seeking advice and awareness of the content and context of powers and duties under these Acts. The findings showed a mix of knowledge, not consistently distributed between MHOs and others, a failure of continuity in training and a wide range of sources accessed to gain advice. This is consistent with findings from other studies (MacKay et al 2011; Atkinson 2007; Killeen et al 2004) as well as from MWC investigation reports (MWC 2006b – 2016b). Reflecting on the discussion in the review of literature on power dynamics in mental health law, this legislative framework retains the concentration of expert power with the psychiatrist, GP and MHO as gatekeepers. Agencies such as

MWC and OPG have been legally established to provide the necessary expertise to support this process and to lead change. However, from these findings, apart from MHOs, those with 'positional power' such as the MWC, despite claims of 97% accuracy in advice-giving, have limited credibility with participants. Frontline practitioners with experience and appointed local experts were participants' primary source of knowledge, indeed the language used to describe the local experts was heroic in nature ("guru", "goddess", "person who will know"). It appears for this group of participants that the level of formal information provision, training and advice, does not adequately equip them to fulfil their duties under this legislation and that ad hoc arrangements are the norm. If local practitioners are seen as the most reliable sources of advice, the potential lack of legal focus, may be a factor in variable use of the framework. However, the level of concern about contradictory advice should, when seen in isolation, be treated with caution. As noted earlier therapeutic law is by its very nature less precise, decisions need to be taken on a case-by-case basis and there are political factors and policy imperatives which may legitimately influence views about expected outcomes. Nevertheless, if this advice is so variable, leading one participant to say "why bother", frustration may lead to random, ill-informed decision-making, which would be much more problematic.

4.4 Theme Two: Use of legislative framework

4.4.1 Introduction

Understanding the ways in which participants use the framework will provide insight into the credibility of the framework from their perspective and provide further insight into how they interpret the law. The focus here is on actual practice rather than

debate about the meaning and intention of law. Inevitably other inter-related areas will be mentioned, particularly risk, assessment and core criteria for intervention under these Acts. The discussion will thus examine not just the reasons for use, or not, of the legislative framework, but with regard to its credibility, consider how far the underpinning principles of intervention, link to an evidence base from practitioners' perspective. The discussion will also explore complex dynamics where local authorities lead legal interventions, but other professionals have key gatekeeping roles, seeking to better understand these inter-professional processes. Participants' views are also explored, as to the usefulness and relevance of this framework for their day-to-day work, the internal coherence of the framework and its compatibility with wider legal duties. Analysis of these responses may shed further light on the reasons for differential use of the Acts.

4.4.2 Findings

The findings section is divided into broad headings relating to responsibility for interventions, utility of the law, practice issues and interagency roles, further sub-divided into the different Acts where appropriate.

4.4.2.1 Who is responsible for using the legislation in the participants' area?

Views varied across areas as to *actual* responsibility within community care services as well as *perceptions* of who was responsible, which were sometimes different. A brief overview of responsibilities under each Act, across the different areas, will help contextualise the debate about responsibilities and practice issues. The greatest variation, and disagreement about responsibilities, seemed to arise in relation to the 2000 Act.

The 2000 Act

In Area 2 the MHO provides a report for guardianship applications and the case-holder leads the process, supported by the legal section. In Areas 1 and 3 the MHO, takes the lead. Several Area 3 participants argued that social workers were losing skills by not being involved in applications for their own cases, CM48 commented that "it just goes off to the MHO and you are not even notified about the hearing". CM47 agreed noting that she, along with the adult's family, felt "cut out completely" from the arrangements for admission to care once an order had been granted. The Area 3 MHO group regarded matters slightly differently: "we (MHOs) are quite often ignored even when the subject of it has got a mental disorder" (MHO43). This comment related to similar situations mentioned under the previous theme, whereby an adult protection case conference takes, sometimes legally incompetent, decisions to pursue guardianship without involvement of the MHO, then bring them in to finish the process. Area 1 highlighted similar experience. Most Area 1 MHOs thought that the Area 2 approach whereby case-holders lead guardianship applications was much preferable, both in terms of effective use of resources and in maintaining skills and knowledge across the wider workforce. Additionally, several in the group agreed that keeping the MHO independent from the case holder and associated decision-making processes, avoids any perceived conflict of interest.

Use of 13ZA is closely linked to use of the 2000 Act but was seen as a management or MHO decision in Area 3. This was rather echoed in Area 2, where one participant commented, in a humourous aside, with reference to my own role in the council, "I can't use it cos the management won't let me". In Area 1 although few had even heard of 13ZA, most understood policy to state that guardianship would only be used

where there were objections to the proposed intervention, regardless of the level of incapacity of the adult. Issues around 13ZA are looked at in more detail later under the heading of 'Assessment' in Theme 5.

The 2003 Act

There was little disagreement amongst participants that the 2003 Act principally concerned MHOs within local authorities. However, the CM/MHO group in Area 1 asserted that community care staff often undertook Duty to Inquire responsibilities (s33 of the 2003 Act) without realising it, MHOs only got involved where a warrant to gain entry was being considered. Reflecting some negativity in the Area 3 MHO group, it was noted that whenever the word "mental" appeared in referrals these were "offloaded" to the MHO team or the CMHT.

The 2007 Act

The 2007 Act was regarded differently from the above acts across all areas, where the driving force was largely seen as managerial. Those principally involved were not MHOs, but care managers or intake/reception team workers. A care manager in Area 2 referred to the 2007 Act as "administratively driven". The general view of the Area 2 MHO/CM group, including several NHS employees, was reflected in comments that "the whole thing about adult protection - it is everybody" (CM28) or it is "just the same as children isn't it?" (CM29). A few were clear that social work is responsible: it "is there in black and white", referring to the role of Council Officers.

The Area 1 MHO/CM group, with similar comments from other groups, strongly welcomed improvements and formalised processes around information sharing and joint responsibility within the 2007 Act, CM12 characterised past approaches thus:

“traditionally social work would have been left on their own carrying the can”, and “everyone says ‘well really it is a social issue’...and puts the phone down”.

4.4.2.2 Utility of the law in practice situations

Positive and negative views were expressed about helpfulness or otherwise of the legislative framework. More generalised impressions of the legal framework are considered under the final theme in this Chapter, but here the focus is on the practical applications of the framework. Most responses were prompted by specific questions within the case studies as to whether the law would help in that situation and if not why not, however, participants often cited actual practice, by way of illustration. These are grouped under situations where, according to participants, the law is helpful and situations where it is less so.

Situations where the law helps

One Area 3 participant cited a case where an older person was at high risk, but wanted to remain at home. Use of guardianship brought about a positive outcome through involvement of advocacy, case conferencing and ultimately the decision by the Sheriff. The Area 2 MHO group discussing how a s47 certificate (the 2000 Act) could help manage Harvey’s medication. They further demonstrated knowledge of covert medication processes, and the role of the MWC, in related case examples. Area 2 MHOs viewed early intervention as important, referring to potential use of the 2000 Act in Harvey’s case. One Area 1 MHO commented that the law provided useful back-up, supported by a care manager who described 2007 Act Banning Orders “as a sort of stick for people to some degree”, to deter perpetrators of abuse. CPNs in the Area 2 CM group, regarded CTOs as very helpful in promoting compliance, improving regularity of contact and mobilising services for people. In Area 1, the MHO/CM group identified benefits in using the 2007 Act as a gateway to

other legislation, suggesting that it encouraged multi-disciplinary working, this latter point echoed by Area 2 MHOs, in relation to the overall framework.

Several situations were described where consideration of legal processes led to positive outcomes, albeit legislation was not ultimately used. A few Area 2 participants saw removal orders (2007 Act) as potentially helpful. One participant described a situation where, following a removal order, a man settled after initial reluctance, without need for longer term legal intervention. Similarly, in Area 1 MHOs discussing Victor, suggested that guardianship processes helped focus minds. Many participants identified positive aspects of guardianship processes, such as case conferences, focused on service user and carer's views, which reportedly helped resolve situations even where the 2000 Act was not used. The Area 1 MHOs further noted that rigorous assessment processes, sometimes facilitated informed agreement for a move to care anyway, obviating the need for compulsion. One or two participants reflected on the Killeen (2008) guide to assessing capacity, when discussing supported decision-making. Area 1 MHOs believed that, in general terms, the legal framework has helped to spread a largely positive culture of risk assessment.

Situations where the law has not helped or has led to poor outcomes

Several CPNs, from the Area 2 CM group, argued that delays in providing services or supporting discharge from hospital, arose from procedural problems when invoking the 2003 Act. One care manager, supported by a CPN, added that detention of older people under the 2003 Act, rather than community options, unduly hastened admissions to care. Many participants regarded Guardianship as effective in removing people from high risk situations and securing their safety, usually in care

settings, but less effective in supporting care at home. Area 3 MHOs almost unanimously concluded that in Victor's case the law was more likely to confuse and that what was needed was "good social work practice". One MHO commented that legal processes can be empowering in the early stages, but that the emphasis seemed to be on limiting choice in later interventions. A few Area 1 and 2 MHOs expressed the view that the Acts often do not provide solutions, one participant arguing that the 2000 Act lacked definition and was too "grey at times". Area 2 CMs found the inability to enforce orders under the 2007 Act particularly unhelpful. Area 1 MHOs, further reflected that many 2000 Act powers can only be enforced in care settings, and that only the 2003 Act was widely enforceable. They also noted that the 2003 Act is the only Act with any meaningful urgent procedures the lack of which under the 2000 Act was identified as unhelpful by the Area 2 MHO/CM group.

Relevance of the framework to participants' working environment

Briefly summarised, the 2000 Act was seen as relevant to older peoples' teams and learning disability, the 2003 Act to adult mental health services, but relevance of the 2007 Act seemed to be broader. Area 1 CMs noted that they were often involved in the granting processes around Power of Attorney, but that otherwise the 2007 Act had greatest relevance to their day-to-day work. Area 2 and 3 MHOs viewed the 2000 Act as most relevant to older people and learning disability teams and argued that "social workers are the movers and shakers" of the 2007 Act. Area 1 MHOs on the other hand, described their increasing involvement in all adult protection case conferences, despite local policy which only required their involvement where mental disorder or incapacity was evident. Many participants across Areas 1 and 2 identified the 2003 Act as the preserve of adult CMHTs. One Area 2 CPN described the 2000 Act as an alien concept to adult psychiatry. She cited a case where she believed a

man under the age of 65 had significantly impaired capacity and was struggling at home. She could not persuade psychiatrists to support action under the 2000 Act, stating that personally she found the law confusing.

As noted earlier, Area 2 and 3 MHOs viewed use of 13ZA, as a management decision, so as practitioners reported less engaged in the associated processes. On a more general note, several of these MHOs argued that care managers and MHOs have very different roles, suggesting that care managers will "just try to manage the situation, where MHOs will look at use of the law" (MHO18).

4.4.2.3 Practice examples

Substantial comment around how the Acts were actually used was offered, clearly relevant to the overall purpose of this research, particularly in exploring differential use of the Acts across different areas. Many comments related to the case studies, but participants also digressed to discuss other cases or to make wider generalisations about use of the law. The first part of this section is a representative sample of more general comments from the different areas and the second part looks at comments in the context of the case studies.

Several participants reported utilising principles of the Acts to inform their practice. One Area 1 MHO referred to his local authority seeking a Part 3 arrangement (the 2000 Act) to "grab" unpaid residential fees. He was not convinced this met the "benefit" principle (s1(2), the 2000 Act) for the adult. The Area 1 MHO/CM group were very keen to highlight these principles before thinking about placing Victor in care or taking radical action in respect of Harvey. One MHO in Area 3 MHO/CM group, backed up by a care manager and unchallenged by others, asserted that

neither power of attorney nor guardianship allow for the use of force. Issues around the interaction between 13ZA and continuing power of attorney were confused, even by MHOs, in the Area 1 MHO/CM group and in fact one care manager was surprised that 13ZA only applied to adults who lacked capacity.

MHOs in the Area 3 MHO/CM group asserted that many admissions under the 2003 Act were not based on a formal diagnosis of psychotic illness. In their experience the 2003 Act was often used to 'secure' someone and the 2000 Act for longer term measures. Interestingly an Area 2 CPN reported that the psychiatrist attached to their team did not believe the 2003 act could be used to address self-neglect. Area 3 MHOs reported that very few guardianship cases were held by adult CMHTs.

One Area 2 CPN asserted that there was a significant increase in the number of people subject to CTOs, though this is not borne out by statistics (MWC 2009a, 2007a). Another Area 2 CM expressed concern around poor knowledge of processes of recall and use of warrants amongst medical staff. One CPN identified a case where there are "huge amounts of money at stake" (CM29), but no-one can agree if he meets criteria under the 2000 or the 2003 Act, so he remains vulnerable to exploitation. The Area 2 MHO/CM group, viewed different processes for NHS and local authority staff under the 2000 and 2007 Acts as a barrier to using the legislation.

The MHO group in Area 1 had surprisingly mixed views as to whether, or how much, the 2007 Act was used. Whilst MHO4 asserted it is not used much, MHO1 commented that adult protection case conferences, "not directly connected to the Act

by some", are real evidence of how this Act has changed process and culture. Participants generally seemed comfortable about undertaking 2007 Act investigations despite lack of hard evidence relating to vulnerability of the adult or guilt of the perpetrator. Others in the group noted that any Council Officer can intervene under the 2007 Act, questioning the experience of staff who are assigned lead roles and the adequacy of quality control measures.

One Area 1 CM group participant cited a case conference where use of all three Acts was planned, the 2007 Act serving as a gateway to the other two. Many of the Area 3 MHO group similarly identified the "gateway" concept, noting that in 2007 Act investigations protection plans were more likely to be underpinned by other legislation. One MHO in the Area 2 MHO/CM group cited potential for using one Act to address problems with another, whereby abuse by an attorney might be addressed utilising investigative powers of the 2000 or 2007 Acts and banning orders under the 2007 Act.

Case studies

The following paragraphs report on specific findings relating to use of the framework, grouped under responses to each of the case studies, to help provide structure.

Harvey

Few participants expressed concern about Harvey's medicine being concealed, indeed several of the Area 2 CM group (predominantly CPNs) were reluctant to interfere at all, asserting that benefit to Harvey was paramount. Many participants across the groups feared alienating Harvey's parents by challenging their actions in concealing medication, in the context of overall utility of the legislation an experienced CPN (CM36) commented "if he has to have that medication and that is

the only form he can take it in, what can you do?". One Area 2 MHO identified this as assault, but was unclear as to the appropriate professional response. She suggested, with agreement from others, that scrutiny under the 2007 Act might help. Otherwise there was limited recognition of the human rights or legal aspects of concealing medication. When reminded of covert medication protocols by myself as facilitator, most groups agreed that something should be done to formalise arrangements. The Area 3 MHO/CM group and an Area 2 CLDN incorrectly asserted that Harvey's anti-epileptic medication could be enforced using the 2003 Act. CPNs in the Area 2 group expressed doubts about this approach. None of the Area 2 CM group identified the MWC role in covert medication and only the Area 1 MHO/CM group specifically identified s47 of the 2000 Act as a possible means of regulating covert medication. There was otherwise little differentiation about attitudes to covert medication between participants, disciplines or areas.

Similar reluctance to intervene was displayed when considering Harvey's financial affairs and it was only when asked how they might respond, if it was clear that Harvey was subject to exploitation, that measures under the 2000 Act were discussed. The Area 2 MHO group discussed a 2007 Act banning order targeting Harvey's friends, but one participant urged caution for fear of destroying what might have been Harvey's only social support, asserting there may be value to these friendships, exploitative or not. The Area 2 CM group were concerned about "enforceability" of a banning order, suggesting that encouraging attendance at the day centre might help him to form better friendships, thus avoiding the need for intervention with these apparently exploitative friends. Many participants were again concerned that legislation might disrupt relations with his parents.

Most did not see the duty to protect as a priority in this case, though a few accepted that financial interventions under the 2000 Act may be useful at some point. However, the MHO group in Area 1 believed 2007 Act investigative processes might help establish if there were significant risks at play. There were mixed views in this group as to how quickly practitioners would identify financial risks for Harvey, but most acknowledged such risks should be considered. A few participants reflected on the interface between this framework and other legislation in relation to finance, for example between the 2000 Act and appointeeship under Department of Work and Pension rules or between the residual powers of the National Assistance Act 1948 and the 2000/2007 Acts.

The Area 3 MHO/CM group members believed that using the 2003 Act to enforce Harvey's attendance at a day centre would not be welcomed by service providers. The MHO groups in Area 1 and 2 explicitly rejected any role for the 2003 Act in intervening with Harvey, whilst most others did not even mention the 2003 Act in relation to Harvey.

One Area 3 CM's enthusiasm to address his parents' failure to cooperate through investigative powers and a protection plan under the 2007 Act was met with a lukewarm response by others. Similar scepticism greeted one participant in the Area 2 MHO/CM group who suggested removing Harvey using a 2007 Act Assessment Order. CM24 acknowledged that if this was a suitable care placement his parents might then accept the move, describing such use of the law as a "carrot".

Across the groups, use of any legal intervention was resisted, particularly by Area 1 and 2 MHO/CM groups who saw good social work practice as being the way forward, not use of law, which they saw as a last resort. The Area 3 MHO/CM participants highlighted the importance of advocacy when considering use of the legislative framework.

Victor

MHO27, reflected a major issue about use of the 2000 Act for many participants in cases such as Victor's. He described practitioners resorting to deception and persuasion, rather than legislation, to move someone into a care home, so commonly that "scooping up" had become an accepted slang term for this process. He rehearsed the kind of conversation that might start this process as "come on off we go for a nice ice cream". Although seen as the "old way" of doing things, he asserted that "I very much see this still being used when in actual fact the Act should be used". MHO25 agreed, citing a similar term, "the magic bus" which she had heard used. Whilst most were opposed to this, a few participants (MHO and CM) in Areas 2 and 3 thought that this was potentially more humane than putting people through protracted legal processes when the outcome would be the same.

Area 2 and 3 group members were mostly clear that 13ZA could not be used if Victor was opposed to moving and a few identified the fact that Continuing Power of Attorney was only a financial measure, so could not authorise care. In contrast, the Area 1 MHO group view reflected the earlier noted policy, whereby no order or 13ZA would be preferred to guardianship in such cases. MHO1 described himself as "non-interventionist" in this regard, suggesting that legal measures would only be taken in the face of active resistance to intervention.

There were mixed views across the groups as to whether Victor could, or should, be persuaded to stay in hospital. MHOs 41 and 43 asserted that the 2003 Act would not be used, because Victor was not actively trying to leave: “it is that old chestnut of capacity and how is that affecting his ability to make proper decisions and informed choice” (MHO41). The Area 1 MHO group looked very closely at whether someone in Victor’s situation might be detained. MHO1 thought out of hours MHOs could find themselves “strong-armed” into consenting to detention to appease a doctor’s concern that he was not “actively consenting”. MHO5 who worked in ‘Out of Hours’ agreed, but noted from her experience that it was more often the MHO/care manager, not the doctor pushing for detention. MHO3, strongly backed by two others, noted that detention is not routinely considered for many people, like Victor, in locked wards.

Area 1 MHO/CM group members largely agreed that Victor was not trying to leave and therefore not detainable. MHO10 argued that technically there was an argument to detain him, but that in practice this would not happen. Similar discussions arose in the Area 2 CM group, most agreeing he would not be detainable at present. One CPN argued that in these circumstances, far from detaining him, he should be allowed to go, with appropriate support, and his abilities at home should be assessed. An area of considerable disagreement between Area 3 MHO and CM participants arose, when the latter suggested that Victor might typically be subject to s47 of the 2000 Act, which locally would be considered sufficient authority to keep him in hospital. When asked about this MHO43 in the Area 3 MHO group responded

“good grief! No he wouldn’t! That shows the knowledge of our colleagues doesn’t it?”.

Area 2 MHO and CM groups considered investigating the Attorney under s10(1)(c) of the 2000 Act, if he was acting against Victor’s interests. The Area 2 CM group cited Victor’s deteriorating mental state as an increased risk factor, which might eventually necessitate guardianship. One CM in the Area 2 CM group emphasised the 2000 Act principle of taking the adults views into account, pointing out that Victor may simply not understand the meaning of staying in a care home and that with proper explanation he might be able to make an informed decision.

Drew

Drew’s case evoked very strong feelings, frequent use of emotive language and clear agreement that legal measures of some sort should be sought. In the Area 3 CM/MHO group, one MHO stated that he should be “taken off the streets immediately and subject to an assessment order (2003 Act)”. When asked whether this might be seen as punitive, another MHO denied this asserting that “I’ve learned by experience”. Another MHO in the group stated “it is a shame to criminalise him”, prompting MHO46 to note that different MHOs have very different views on these matters. A CM added that if Drew was assessed to have made informed choices “in that case lock him up”. This group were quick to identify criteria under the 2003 Act to intervene in Drew’s situation and did not see a role for the 2000 or 2007 Acts. Similarly, the Area 2 MHO group saw the 2003 Act and CPSA as the way forward, though urged caution, if this was his first detention, due to longer term implications of such a decision.

Area 2 CMs unanimously agreed that Drew should be subject to the 2003 Act, though one CPN doubted if a STDC would apply, if he was not acutely unwell. Given that his mood cycle might include times where he lacked capacity in some areas, a few participants considered the 2000 Act. One CLDN observed that alcohol might be masking or otherwise impacting on his symptoms.

4.4.2.4 The impact of others' roles on use of the legislative framework

Responses are grouped here under the principle roles mentioned, to emphasise the diverse influences on use of the law.

Sheriffs

Sheriffs in Area 3 were reportedly reluctant to grant orders under the 2000 Act, unless it was intended to act on the order immediately. Consequently, according to CM48, it is difficult to intervene until a crisis is looming or has happened. Area 1 MHOs were concerned about local sheriffs refusing 2007 Act applications, or applying the burden of proof at criminal rather than civil level, in turn influencing the council solicitors' inclination to act. Reflecting comments across several groups, 3 MHOs in the Area 2 MHO group discussed in depth the frequent failure of sheriffs to accept MHO recommendations to refuse guardianship applications or remove un-necessary powers.

Regulators

Participants commented on the MWC repeatedly and made some reference to the OPG. Several Area 1 MHOs reported that the MWC criticises MHOs for not challenging applications, yet fails to criticise sheriffs for ignoring MHO recommendations to amend or refuse applications. An Area 1 MHO highlighted the MWC role in covert medication, citing a case where a patient routinely refused depot medication and was subject to violent restraint to impose this, sometimes involving

the police. The MWC reportedly refused to sanction the proposed use of covert medication, leading to doubts over what the law can authorise. In one case the MWC was described as having become over-involved in court processes relating to a Guardianship application. Participants' experience of joint investigations with the OPG was limited and a few who had experienced this felt the level of co-operation from the OPG was poor.

Council and NHS legal departments

As highlighted earlier, with some exceptions, most reported that council legal sections were not particularly co-operative or helpful, despite having a central role in 2007 Act procedures, according to Area 1 MHOs. NHS legal departments were viewed by participants as largely disengaged from this legal framework.

Police

Area 3 identified a good relationship with police, noting that they generate a lot of 'Adult Concern' referrals under the 2007 Act. In contrast, Area 1 and 2 staff reported that police still frequently make "informal" referrals rather than use the law and lacked formal processes for the 2007 Act. Understanding of capacity by many police officers was seen as an obstacle to intervention, according to participants across several groups. Even if an adult was considered to be "at risk of harm" (s3, the 2007 Act), the police would not act without the individual's active consent, unless the adult was assessed as "incapable".

Two MHOs in the Area 2 MHO group and several in the Area 2 CM group, referred to police inaction in response to concerns. In one case a nephew was financially abusing his uncle and in another a woman had faked her mother's signature to withdraw money from her account: "the attitude is social work can just deal with it"

(MHO19). This failure to engage by the police, reportedly led to other problems, as banks refused to co-operate without a crime number. One Area 2 CLDN provided examples where police were very reluctant to press charges when assaults occurred on wards. She argued that this left staff vulnerable as patients perceived there were no consequences for sometimes violent assaults. Other participants across the groups reported similar examples in community and hospital-based work, A participant in the Area 1 CM group asserted that people with learning difficulties should be prosecuted, where appropriate, to ensure awareness of consequences.

NHS Staff

Area 2 CPNs reported frustration, that as joint team members, they were not empowered to act as Council Officers or under the 2000 Act. CM48 was concerned at the power invested in psychiatrists to detain someone like Drew indefinitely. This is discussed in greater detail under later themes.

Proxies

Wide support was voiced for the commitment and contribution made by relatives and friends taking on the role of attorney or guardian. The importance of providing support where things were going wrong rather than seeking to remove powers was widely emphasised. The role of proxies is explored in more detail under Theme 4.

MHO/Case manager

Conflicts and complications were identified across all three areas about the MHO role in guardianship applications and to a lesser extent in 2007 Act processes. In Area 3 there was evidence of inter-professional rivalry even within social work, MHO43 with support from others in the MHO group, commented that social workers “enjoy” having a prominent role in the 2007 Act, characterising their view thus: “this

is our baby, we can deal with it and it is they (MHOs) have had sort of the kudos for ages now we have got it, we are ASP and we don't need them".

Similar aspects of intra-agency rivalry were evident in other areas. Many Area 2 MHO participants argued that care managers were ill-informed with regard to law and adult protection and NHS staff even more so. There was evident resentment about being at the "beck and call" of community care staff, as one MHO put it. In Area 1 as reported earlier MHOs were unhappy about being compelled to attend adult protection case conferences, but they were slightly more positive about providing support to community care staff. Many MHOs across the groups identified benefits in longer term involvement with a service user rather than being "parachuted in" to do a report. MHOs who worked in other disciplines found Care managers' knowledge of the person and community care systems helpful.

Advocacy

Despite the emphasis on advocacy throughout the 2003 and 2007 Acts, the role was not really explored by participants, even within the case studies. Interestingly it was a CPN in Area 2 who suggested this should be pursued for Victor.

4.4.3 Discussion

This theme reflects reported use of legislation, in an effort to shed light on the credibility of the framework for participants and better understand their reasons for use or otherwise of the legislation. Understanding of participants' interpretation of the law is informed to some extent by their view of the evidence base, their perceptions about the utility of the framework and the roles of others. These findings may reveal reasons for variation between areas. The issues here are complex so this section is split into relevant subsections to try and bring some order to these different strands.

4.4.3.1 Reasons for use or otherwise of the legislative framework

Even within this heading there are several strands so further sub-headings are used to group responses.

Use of the framework across different disciplines

Views were sought and volunteered around roles and responsibilities and it would appear different approaches and perceptions influence local use of the framework. Use of the 2000 Act, and related staff responsibilities, seemed to vary most across areas. Older people and learning disability teams reported most use of the 2000 Act. CM groups mainly believed the 2003 Act was used by CMHTs, but MHOs reported employing the 2003 Act in respect of adults from many backgrounds and for older children. However, in terms of discharging local authority functions most participants viewed MHOs as having the lead role and otherwise only adult mental health/CMHT staff claimed to have much knowledge of the 2003 Act. Duty to inquire under s33 of the 2003 Act was reportedly undertaken, informally, by CMHTs in Area 1.

Participants in this study perceived Adult protection under the 2007 Act as a core social work activity, somewhat removed from MHOs. Many believed adult protection processes were administratively driven and that senior managers were increasingly taking a lead role. MacKay et al (2011) also found that senior managers were routinely engaged in adult protection case conferences and that the thresholds for involvement of other disciplines, even within social work, seemed to vary greatly. Despite the fact that local authorities produce bi-annual reports published on the Scottish Government website, the only national report was published by Ekosgen in 2013, so it is difficult to get a national over-view of how it operates. High levels of Government funding, relative to the other two Acts, may explain the interest of

management in the 2007 Act, as local authorities may be keen to demonstrate outcomes. This connection between funding and Government interest was reflected in the views of a few participants in this study and was obliquely referred to by Mackay et al (2011).

Echoing findings by MacKay et al (2011), most participants identified and welcomed the multi-agency component of the 2007 Act, albeit that many saw the lead role for social work as inevitable and not necessarily positive. Since the focus groups an amendment to the 2007 Act regulations (s3 Community Care and Health (Scotland) Act 2002 (Incidental Provision) (Adult Support and Protection) Order 2012) allows NHS staff to act as council officers when carrying out delegated functions. However, George Kappler from the MWC (2012) described this amendment as ill-thought out, underhand and designed solely to resolve a problem created by merging health and social work services in Highland. Participants clearly believed that activity under the 2007 Act principally authorises inquiry and investigation, not the actual orders.

Returning to the overall framework, little evidence was apparent for Patrick's (2008) assertion that "The current practice appears to be to seek a compulsory treatment order where the patient's needs are specialist psychiatric services and to use welfare guardianship if the main concern is the adult's care arrangements" (Patrick 2008 p39). This suggests that the Acts are interchangeable, where in fact the criteria are very different. Surprisingly, many studies and commentators make reference to differing use of the Acts, but none seem to address the issue of restriction of expertise and experience to particular service areas identified by participants (MacKay 2009, 2011; Atkinson 2007; Gordon 2004; Killeen et al 2004). This might

well merit further research, as it may underpin variable use of the law, which in turn may support the earlier noted need for a more comprehensive training strategy.

This differing focus depending on discipline, might suggest the Acts are not as closely linked as intended. Although each Act contains powers and duties concerning investigation and inquiry, participants reported that most inquiries took place under the 2007 Act, even at that early stage of implementation. Research certainly backs this up in that, of almost 30000 referrals and 1650 investigations across Scotland, only 137 protection orders were enacted between 2010 and 2012 (Ekosgen 2013). However, statistical information about inquiries under the 2000 and 2003 Acts is not collected, so comparisons are not possible. Findings from the three areas suggest investigative functions are invoked very differently across localities.

Impact of differing roles under the Acts

The findings highlight the impact of a wide range of roles on participant's ability to discharge functions under the Acts, few of which were identified in related literature. Negative perceptions about legal sections and their potential for blocking some 2007 applications or warrants, were not reported in literature, but if replicated more widely may be relevant to differential use of the law across Scotland. Regulators have clearly influenced thinking in subtle ways, not always connected to their legal powers. For example, the MWC do not have statutory powers to veto covert medication arrangements, but participants, from all three areas, apparently accept that they do.

Reflecting on the influence of sheriffs, Area 1 MHOs argued that, whilst the MWC blame MHOs for not challenging inappropriate powers or measures in guardianship

applications, the real issue is with sheriffs, who participants saw as actively obstructive, when considering applications under the 2000 and 2007 Acts. The review of literature highlights cases where sheriffs held very strong views about applications, for example Muldoon (Scottish Courts 2004) and Donnet (Scottish Courts 2007), wherein local authorities are criticised for not using guardianship to underpin the provision of community services. MWC policy statements steer local authorities away from guardianship (MWC 2004, 2005), yet their inquiry reports criticise apparent failure to use guardianship, to protect (MWC 2008b) or to underpin care admissions (MWC 2012c). Participants explicitly reported struggling with such mixed messages. Local authority approaches to admission to care were markedly different between Areas 1 and 2, the latter promoting use of guardianship and the former avoiding statute in the vast majority of cases. The influence of 13ZA is reflected on in more detail under the theme of 'Diagnosis, Assessment and Consent'

The police and the procurators fiscal were frequently cited in discussion, reflecting debates in Justice Denied (MWC 2008b), whereby charges were not always pursued for perpetrators of abuse against people with learning disabilities. Participants clearly identified occasions where the police did not want to get involved, whether in family situations or in hospital settings, sometimes justified on the grounds that the procurator fiscal would not pursue charges anyway. Later research findings showing high numbers of police concerns reports (Mackay et al 2011), were already reflected in Area 1, despite the fact that the focus groups took place shortly after implementation of the 2007 Act.

One surprising finding from this theme is the intra-agency conflict between MHOs and care managers, particularly around use of the 2000 and 2007 Acts. Many MHOs reported lack of consultation and involvement in decisions to pursue guardianship, often placing them in the awkward position of advising that the criteria are not met. According to the MWC (2008b), MHOs should be routinely involved in casework and have direct contact with the service user concerned, prior to being invited to case conferences. This it is argued, better enables MHOs to provide advice, guidance and support to community care staff in identifying areas where they might, or must, intervene. Some care managers on the other hand viewed MHOs as elitist and as distancing them from the decision-making, whereby the care manager instigates guardianship, but is then excluded from the process. This was most evident in Areas 1 and 3 due to policy which dictates that the MHO should have the lead role in guardianship applications, unlike Area 2 where the case-holder takes the lead. Even where the MHO leads, participants asserted that there was little 'casework' involvement. Whilst valuing the role of the MHO and not wishing to see the MHO any further distanced from the process, most participants favoured the approach whereby the case-holder takes the lead. Commentators reviewed for this thesis have not identified this dynamic, so the differing role of MHOs in these processes certainly merits further research.

Finally, somewhat challenging the view that health staff are tied to a medical model of intervention, it was a CPN rather than an MHO who expressed concern over the power of psychiatrists to have someone detained indefinitely. This was a one-off comment but it is curious that MHOs did not raise such concerns. Most orders are subject to renewal processes which require circumstances to be reviewed, but it is

nevertheless true that, as lead clinicians, psychiatrists can seek repeated renewals of 2003 Act measures, which need only be reviewed by tribunals bi-annually. Psychiatrists also have a role in supporting long-term compulsion through 'indefinite' guardianship orders under the 2000 Act, the subject of repeated concerns expressed by the MWC (MWC 2012f, 2005, 2004). Statistical information and research in this area is again limited, so further research over long-term use of compulsion could be beneficial.

4.4.3.2 Principles and values

Participants were less inclined to explicitly explore principles of the Acts, however, they were forthcoming about their views and value base. These views are reflected on throughout the themes, providing insight as to how far values, and by implication principles, impact on participants' use of the law. For example, least restrictive measures and participation were fully discussed in the context of implementing legal measures, rather than as specific legal principles. Participants were not guided to discuss principles by direct questions or within case studies, which may explain why their answers focused more on statutory measures. Few participants seemed to understand that principles had equivalent legal weighting to measures (such as CTOs).

There was surprisingly little debate around justification for compulsion or efficacy of treatments amongst participants. This study seemed to mirror views, expressed in the literature, that most care professionals view admission to hospital for treatment as essentially beneficent and effective (Atkinson 2006; Bean 2001; Shorter 1997). The more vigorous debate, with one or two exceptions (for example a CPN challenged the need to keep Victor in hospital), was around capacity to agree to

interventions rather than efficacy of approaches. Surprisingly few participants expressed concerns about the impact of institutionalisation, or reflected on the theory (Goffman 1968), when considering hospital admissions for Drew or Victor.

4.4.3.3 Using the Acts

This part of the discussion examining how participants used the law is split into a number of strands, to provide clearer focus.

Participants' views about usefulness and relevance of this framework to their day-to-day work

Despite the apparently innovative nature of this legislative framework, this study suggests that powerful personalities or groups and traditional ideas around role and use of legislation, strongly influence how law is used. Many viewed the law as useful in achieving objectives, but were frustrated by mixed messages, from management and regulators, and cumbersome processes, particularly when seeking guardianship and banning orders.

Participants' views were sought as to the utility of the framework in their day-to-day work, through the case studies and more general discussion. Alongside their responses to set questions, participants cited case examples to illustrate their views. There was wide agreement that the different Acts complement each other, to some extent, and that the 2007 Act has enhanced the ability of statutory authorities to metaphorically, and sometimes literally, get their "foot in the door", allowing investigations to take place sooner.

As outlined in the review of literature the Scottish framework is perceived to have avoided problems encountered in reforming mental health law across other parts of

the UK (DHSSPS 2007; Atkinson 2006; Grounds 2001). Reflecting on other systems the Scottish legislative framework seems to be fairly unique, with its strong emphasis on principles, empowerment and user involvement and coherence across the three component Acts (Scottish Government 2011). In Australia the emphasis is often on confirmed diagnosis (Greig 2002), whilst many states in the USA, prioritise risk to others (Atkinson 2006; Hiday et al, 2002; Bean 2001). Despite apparently person-centred approaches many participants seemed to favour avoiding use of the 2000 and 2003 Acts. However, when reflecting on Victor's case, many expressed discomfort about perceived routine 'de facto' detention of older people in hospital. In terms of the 2007 Act many participants accepted surprisingly low thresholds for investigating allegations, albeit many others identified potential for the erosion of human rights. For example, several participants regarded the "threat" of the law as useful in focusing minds, but did not perceive this as contrary to the spirit of the legislation. Section 47 of the 2000 Act was perceived to have simplified processes for imposing medical treatment, by the few who were aware of it, but important debates about enforceability were not raised (MWC, 2012g, 2011a)

Increased emphasis on risk assessment was identified by a few participants, but many linked this to unhelpful and lengthy bureaucratic processes to enact measures across the legislative framework, an issue identified by many commentators (MacKay et al 2011; MWC 2010a, 2008b, 2007a; Atkinson 2007; Killeen et al 2004). Participants and commentators were concerned at lack of urgent measures across the framework. Whilst shorter term detention under the 2003 Act could be invoked quickly, participants identified delays caused by waiting until a person's mental state deteriorates sufficiently to meet the criteria. This matter is not currently considered

within the review of the 2003 Act (Scottish Government 2013, 2012b, 2009). Proposals for reform of the 2000 Act (SLC 2014, 2012) do include urgent interventions, but consultation is at an early stage. Keenan's (2012) suggestion, that Intervention Orders (s53, the 2000 Act) are increasingly being used to expedite responses under the 2000 Act, was not mentioned by participants.

Contrary to perceived intentions of legislators, it was concerning to note that many participants believed the Acts can dis-empower service users, leading to limitations of choice, shortcuts in decision-making and an unseemly rush to incarceration. In a case like Victor's, many believed that local authority would use guardianship to simply incarcerate him in an institution, rather than try the more time-consuming, potentially costly and ultimately unenforceable option of providing intensive community care. Participants generally only viewed the 2003 Act as enforceable, albeit many argued that guardianship or power of attorney could be used to compel someone, who was not actively resistant, to remain in a care home. Enforcement of 2000 Act measures in the community is not discussed by commentators and proposed reforms do not address this, perceived failure to adhere to principles or the need to provide better support for community care (SLC 2014, 2012; Dawson et al 2009a).

The evident confusion over use of the Acts, and enforceability or otherwise of certain measures, may well be fuelled by mixed messages from Government, regulators and commentators (Scottish Government 2007; MWC 2007b; Killeen et al 2004). This debate was rehearsed in some detail in 2.11 but briefly stated: where enforcement of decisions about care is required, power of attorney does not provide sufficient

authority (MWC 2005, 2004) The MWC argue that guardianship should be sought for this purpose, Patrick (2009, 2008) disagrees and argues that neither the 2000 nor 2003 Acts provide sufficient legal power to impose deprivation of liberty and calls for major reform. Despite this high level debate, Recommendation 9 of the SLC report on the 2000 Act (SLC 2014) is clear that attorneys should be able to exercise powers where the adult is resistant. This report acknowledges wide-ranging debate on the issue and records, but ultimately dismisses a clear opinion from the Sheriff's Association that only measures authorised by court orders can authorise deprivation of liberty. These mixed messages do little to clarify and much to confuse the issues. Although practitioners only appeared to have limited knowledge of these documents, mistrust of advice from the MWC and other government sponsored sources seemed to underpin their confusion.

Overall then participants' view as to the relevance of the framework to their day-to-day work was mixed. Many viewed the law as useful to achieve objectives, but significant numbers across areas and groups expressed frustration about process issues and a few regarded the law as actively obstructive in achieving positive outcomes.

Interpreting the Acts

The case studies and associated questions sought to obtain participants' perspective on use of the legal framework. In seeking specific feedback through the case studies it was possible to establish gaps in knowledge for participants and, by their accounts, gaps in knowledge for others with whom they worked. Findings demonstrated that there was limited guidance to staff on which Act to use, indeed as noted earlier none at all in Area 3. Areas 1 and 2 had fairly extensive 'operational instructions' and most

participants reported clear management expectations around use of the 2007 Act or 13ZA.

One Area 2 MHO described an interesting interaction whereby the 2007 Act had been used to investigate inappropriate behaviour by a 2000 Act Attorney. Given that there are existing investigative powers under the 2000 Act, using the 2007 Act for this purpose has the potential to confuse. Concerns about boundaries, in terms of 2007 Act investigation processes, were reported across several groups and all areas, but are not specifically discussed by commentators. Findings from this study did however, concur with MacKay et al (2011), in identifying increasing use of the 2007 Act as a gateway to further action.

Many Area 3 MHOs and care managers argued that it was not possible to use force under the 2000 Act. Few participants across the groups cited s70, and none mentioned s3, both sections of the 2000 Act which allow sheriffs to make directions or enforce compliance. Other areas where participants lacked knowledge of the framework included criteria for 13ZA and use of the 2003 Act to address issues of self-neglect. Many participants reported that medical staff, particularly those from general medicine, had little understanding of the criteria for the 2000 or 2003 Acts. This does support the MWCs contention, in several reports, that professionals were unaware of their powers and duties under the framework (MWC 2012a, 2008a).

In other inquiry reports, the MWC has argued, with some justification, that statutory services need to be much more aware of their duties to intervene where risks are identified and to take assertive approaches where necessary (MWC 2012e, 2006b).

In Harvey's case many participants were reluctant to consider using legislation to manage identified risks. In such circumstances, should an overdose of prescribed medication or serious financial exploitation occur, in the absence of legal intervention, the authority would be open to justifiable criticism, unless it could be demonstrated that proper consideration had been given to identifying and managing risk, so-called defensible decision-making (Titterton 2005).

Victor's case raised issues very much reflecting current debate on mental health and incapacity law. One particularly interesting issue was the practice of removing a person to care or hospital without recourse to legislative process or informed consent. Participants noted that this was so common that care managers had coined metaphors such as 'scooping up' to describe the process. A few expressed the view that this was more humane and it is possible there were others who did not wish to disclose their agreement, given the focus of the research and my own role as researcher. Whilst there was broad agreement that the 2003 Act underpinned hospital admissions and guardianship authorised care home placements, differences in expectations and approach between the Areas examined became evident. The Area 3 CM/MHO group asserted that compulsory hospital placements for older people were often authorised by s47 of the 2000 Act, an interpretation robustly disputed by the Area 3 MHO group and not mentioned by groups in other areas. Oddly Patrick (2008) specifically argues that this is legally competent, despite her reservations expressed elsewhere in the same document that 2000 Act measures cannot underpin deprivation of liberty. Despite the wide publicity afforded to the Bournewood judgement (ECHR 720, 2004), over four years before these groups took place, most participants believed that Victor would not be detained unless he

was actively trying to leave. One MHO described how GPs sometimes manipulated Out of Hours MHOs into agreeing to detention of an older person, because they were aware that, during office hours, consultants and MHOs would seek other alternatives. Debate about appropriate means to underpin hospital placements mainly took place amongst MHO participants, supporting the hypothesis in the rationale, that MHOs have greater interest and knowledge in relation to use of legislation.

All the more surprising perhaps that a CPN, suggested that should Victor wish to leave he should be allowed to, providing some safety measures could be put in place. This reflects legislative principles, in terms of respecting users wishes, and challenges 'safety first' approaches (Titterton 2005). As noted earlier, Area 1 stated use of informal measures were common, even before 13ZA, whereas Areas 2 and 3 tending more toward guardianship if there was any controversy about the move. Reported approaches seemed broadly consistent with statistical information available about these authorities.

It is interesting that none of the participants questioned the validity of Victor's initial agreement to power of attorney or questioned how recently he had granted this. This supports findings in the Mr and Mrs D report (MWC 2012h) suggesting social workers are not really attuned to their duties and responsibilities in relation to power of attorney. Care managers rather than MHOs, raised the possibility of investigating the attorney (s10, the 2000 Act) and in line with recommendations around properly assessing capacity (Killeen 2008), most highlighted the need to clearly establish that Victor was incapable of understanding the proposal, as opposed to being deaf or

slightly confused. As non-MHO staff identified the possibility of investigating an Attorney, so too did they identify more subtle legal aspects regarding use of principles in Victor's case, such as minimum intervention and user involvement. This challenged my own assumptions and findings noted elsewhere in this theme, that MHOs will be most conversant with the legal framework and are best placed to advise on its use. Having said that, this specialist knowledge may have been connected with the earlier noted familiarity of older people and learning disability services with the 2000 Act.

Drew's case prompted much more interest from a legislative point of view. His situation was familiar to many participants and there was almost universal agreement that he should be incarcerated. There was wide-ranging discussion around the balance between forensic and civil approaches, which reflected the debate in the literature review and reported public perceptions, that potential harm to others justifies a strong response, including detention and compulsion (Atkinson 2006; Greig 2002; Bean 2001; Hoyer 2000; Prins 1995). Use of criminal procedures to reinforce recognition of consequences for the perpetrator of violence was one aspect of the debate supported by several participants and many provided examples where these procedures can help manage risky behaviour. Reports that police and other professionals were reluctant to pursue criminal proceedings, on the grounds that the alleged perpetrators have mental disorder, suggest that similar concerns expressed in the literature remain relevant (Greig 2002; Bean 2001; Prins 1995).

Most participants, even MHOs, proposed use of civil measures under the 2003 Act, or even the 2007 Act, rather than criminal procedures under the CPSA. The data

collection phase post-dated Scottish Government sponsored training, prompted by the findings of the Mr L and Mr M inquiry (MWC 2006a) and revision of the MOP (Scottish Government 2010e). This was intended to prepare MHOs for working with mentally disordered offenders (MDOs), using formal risk assessment and CPSA processes. It was therefore surprising that MHO participants' knowledge of forensic options was limited. Issues relating to MDOs are considered in much more detail under the theme of Human Rights.

In terms of content analysis (Bryman 2008), there was less emphasis on the legal framework across the Area 2 CM group, of whom nearly 70% were nurse qualified and just under 50% were employed by NHS. The focus instead was on practice issues, risk and human rights. Whilst this might be seen positively, issues around potentially dangerous and illegal arrangements for administration of drugs, and protection from financial exploitation in Harvey's case, were not readily seen as problematic. This may reflect professional differences between nurses and social workers or between MHOs and care managers, a matter which might benefit from further research.

Lack of understanding of the law, differences between areas, teams and individuals, possibly tied in with the earlier noted mixed sources of advice and involvement of other professionals, all seemed to directly influence the way practitioners interpreted and used these legal measures.

4.4.3.4 Concluding thoughts and links to this thesis

Exploration of this theme has brought some clarity to the kind of cases where legislation will routinely be used. In common with many commentators on use of

detention and compulsion (Bean, 2001; Atkinson 2006; Greig 2002), participants were much more likely to invoke legislation to deal with risk to others (as in Drew's case), or outright refusal to co-operate, particularly highlighted when discussing Victor's case. Views on use of legislation where there was seen to be passive compliance was much more varied. This aspect will be examined in depth under the theme relating to diagnosis. Lack of urgent measures across the framework concerned many participants and it was clear that the 2007 Act, whatever the intentions, is increasingly viewed as an ad hoc gateway to the framework and a means of invoking urgent action.

Participants' reflections on the principles and evidence base for legal intervention did not seem to impact greatly on interpretation or credibility of the legislative framework. Rather policy, bureaucratic process, attitudes of others and expedience seemed to dominate. Some wider reflection by participants on the evidence base and principles is interspersed with findings discussed under other themes.

Findings grouped under this theme suggest many possible reasons for local variation in using the framework. The actions of those fulfilling differing roles under the Acts, within social work as well as NHS staff, legal sections, police, sheriffs and to a lesser extent the regulators all seemed to impact on the way legislation is used. This in turn seemed to affect how those carrying out social work functions interpreted the law. For example, the earlier noted lack of direct operational guidance in Area 3, alongside close managerial involvement appeared to affect use of law in that area, with a bias towards 2007 Act investigations. Overall it was clear that different staff groups and different areas had quite different interpretations of the law, for example

in relation to authority to detain and treat in hospital and arranging admissions to care. Differences in approach potentially increase variation, both within and between local authorities.

4.5 Theme Three: Risk Issues

4.5.1 Introductory thoughts

Direct questions relating to risk were included in the case studies, but this theme also emerged from answers to more general questions posed to participants, as to how the legislative framework impacts on their ability to protect and support people who lack capacity or have mental disorder. Participants held strong views about risk and exploration of these perspectives also sheds light on other issues. The findings are laid out to reflect this and focus on the case studies, risk processes, the actions of others and the impact of risk thresholds. Discussion of the findings under this theme shed light on the justification for compulsion, which is closely linked to the credibility of the framework and participants' day-to-day interpretation of the legal requirements in practice. Consideration is given to how views on risk impact on local variation and the coherence or otherwise of the framework. Technical aspects of risk assessment and the political dimension in terms of civil liberties and organisational priorities are also examined, in the context of participants' responses. Political and organisational aspects are considered in more depth under Human Rights and Bureaucracy themes.

4.5.2 Findings

For ease of reference findings are grouped under headings related to the case studies and then under the main codes underpinning this theme, namely risk processes, others' attitudes to risk and risk thresholds.

4.5.2.1 Risks identified in case studies

Victor

There was some commonality in the MHO/CM responses across the areas. Areas 1 and 3 identified risks such as wandering, loss of control, financial abuse and alcohol misuse. The Area 1 group focused more on ethical issues particularly regard for Victor's views, questioning whether his son represented his interests and also focused on the potential for loss of independence and skills, in a restrictive care home environment. Area 2 MHO/CMs also focused on the rights issues, expressing specific concerns over Victor's capacity to agree to stay in hospital and whether lack of legal underpinning potentially constituted a deprivation of liberty. MHO27 identified the risk of Victors rights being over-ruled, using the metaphor "let's go for a nice cup of tea" revisiting the earlier described 'scooping up' concept.

MHO groups focused more on others' roles: the son and daughter as well as Jack, though otherwise identified similar risk issues to other groups. There was more focus on Victor's psychiatric assessment and potentially difficult dynamics around this, leading MHO43 in Area 3, to identify a "very high" risk of losing skills due to inappropriate long-term nursing home care or hospitalisation.

The CM groups focused more on who was reporting concerns and the criteria against which Victor's behaviour was judged, particularly questioning what was

meant by ‘all’ in the statement within the case study that ”all concerned believed he needed to be in care”. A few participants were concerned that Victor’s allegations of theft might be seen as symptoms, rather than be taken seriously. The risk that Victor did not understand his options was also a concern: “if he wants to leave ...rather than look at ... the Act … look at what can be put in place at home to support him ...to manage that risk in the community” (CM36). This was fairly typical of the perspectives expressed amongst the CM groups and NHS staff.

Harvey

The MHO/CM groups all identified administration of medicines as a risk, expressing concerns around Harvey’s knowledge of this and issues of safety, though as noted earlier most were happy to leave the situation as it was, if Harvey was seen to benefit. Loss of control over his life was seen as a risk, partly from his parent’s actions, but also from potential legal interventions. Areas 1 and 2 clearly identified the risk of financial exploitation; indeed, one participant (CM21) identified this as the main risk. The risk of losing Harvey’s voice in the process was highlighted, though a few participants acknowledged he might be happy with his parents taking such a directive role in his life. Several suggested an advocate might help clarify this. Area 3 focused more on risks surrounding lack of consent and risky decision-making, CM7 and MHO8 being particularly concerned as to whether Harvey could make informed choice. MHO10 questioned whether, rather than lose friendships; he could be helped to make these relationships safer.

MHO groups identified similar risks but were less concerned about the potential negative impact of using legislation. Area 3 MHOs, articulated risks of undue influence, over-protection and capacity. Area 1 and 3 MHO groups both identified the

paradox, whereby his parents sought to protect him from exploitation and harmful influences at a day centre, yet seemed unable to protect him at home. Area 1 MHOs described “considerable risk” noting that a mental state assessment should take place urgently.

CM groups placed significant emphasis on risks associated with medication. CM13 described the approach to covert medicine as “ethically and morally unacceptable” reflecting on “echoes of case experience with older people in hospital”. This group, uniquely, questioned whether the medication was in fact necessary at all, highlighting the risk of over-cautious approaches. Examples were led of cases where people had been prescribed anti-convulsants for years, never having had a seizure. Area 2 CLDNs acknowledged the risk of compromising his independence, but also identified risks associated with inadequate resources for people with learning disability. One CLDN suggested involving a speech language therapist to aid communication and participation. Also uniquely, CPNs in this group identified risk to his parents from Harvey’s associates. Most participants were concerned that any intervention might negatively affect family relationships.

Drew

Drew’s was regarded as someone who presented considerable risks, provoking the most discussion across the groups. Risks identified by MHO/CM groups included medication compliance, his mental well-being, safety of others, knives, substance misuse, lack of support networks and escalating “risky” behaviour. The Area 2 group additionally emphasised that his bi-polar illness seemed to be leading him to overstep boundaries with others, potentially provoking retaliation, also noting that “acting” posed a higher risk than “threatening”. Area 3 cited theories on cruelty to

animals and abusive behaviour towards humans, questioning whether the bird was already dead or if he had killed the bird before sending it to the staff member, thereby indicating higher risk.

MHO groups identified similar risk issues, but additionally the Area 3 group suggested that if Drew was a “nuisance” to others this might lead to robust official responses, even if he was not actually behaving “dangerously”. This group also identified the “poor soul” label as a risk, as this might hinder more appropriate responses to his behaviour, namely pressing charges, to help him see that some behaviours were not socially acceptable. MHO5 also identified risk where staff tolerate behaviours such as Drew’s, arising from perceptions that workers’ responses might be seen as “inadequate” when involving police, and discussed risks of not reporting such behaviours. She also noted that previous knowledge of the person may pose a risk of “under-reacting” by police, similarly highlighted in the Area 1 MHO/CM. “If they (local police) have quite regular contact with him, they might know how to handle him and how to manage him so he becomes less of a threat to them, but is he less of a threat to the public and his support workers?” (CM12). CM7 added “Because the police see him as a poor soul it is not ...an indication of how dangerous he might be to staff or otherwise – they have a tendency to think ...’here’s a poor soul’ and hand him over to social work for support” further to which, CM11 added, “aye poor soul to them and they have got the body armour, truncheon etc”. Area 2 MHOs similarly noted that if he believes he can “get away with things then his behaviour might escalate”.

Area 1 MHOs emphasised “active mental disorder” as a significant risk factor alongside concerns that he posed a risk to visiting support workers. Higher risk of retaliation from others was seen as likely if people were not familiar with him. Area 1 MHOs saw the knife as crossing a line: “the dead bird won’t tick as many boxes as the knife” (MHO3).

Area 2 and 3 CM groups almost unanimously regarded Drew as “high risk”, identifying specific concerns around his diagnosis and lack of mental stability. The Area 2 CM group, more than others, questioned whether he was capable of taking responsibility for his actions. They strongly emphasised risk to others regarding his behaviour as high risk and worrying, tempered by concerns over the dilemma of balancing Drew’s needs with the threat posed by his possession of knives. In Area 1 CM13 opined: “you would immediately say get this man off the streets and get him incarcerated”, though Area 2 CLDNs believed that were he admitted to hospital there was a serious risk he would be allowed out on pass prematurely, potentially putting himself or others in danger. A similar case in their area was cited, which was not picked up by the services, with tragic consequences.

4.5.2.2 Risk processes

Many expressed strong views that risk assessment was administratively driven. As CM7 jokingly put it: ”if only it was a laboratory situation – remove the friends, manage the money and see what it equals”. Others however, regarded written record of decisions and assessments as useful, particularly chronologies which helped identify patterns of behaviour. MHO19 described risk processes as comforting “at least you have a plan … having it all written down, sometimes I find that reassuring”.

Area 3 MHOs contrasted robust risk matrix processes for sex offenders, with much less formal responses to MDOs committing similar offences. It was suggested that someone with mental disorder may commit numerous offences, but be diverted from formal intervention: “he is flashing again so we better get him back into hospital, but if you counted hospital admissions instead of offences ...they were coming up as quite severe risk and yet trying to get it taken down that route ...it is easier for the police to bring him in for assessment rather than do all the paperwork” (MHO41). Despite exhortations to prosecute and seek convictions, thereby ensuring offences appear in records, the police and procurator fiscal were reportedly unwilling to act. Referring to Drew, MHO41 suggested “if you put him in the dock the Sheriff is just going to throw it out and so we are going to save some money and we are not going to bother, it happens all the time in general adult anyway”. CM11 noted a similar trend which he felt undermined the ability to use legislation to address risk: “the actual approach sheriffs are taking is totally different… core parts of the legislation are not working properly if the sheriffs have not taken that (issues of risk) on board”. Police attitudes were similarly seen as unhelpful in Area 2. MHO25, supported by CM26, stated that ”time and time again” police don’t take offences seriously and do not arrest people or put them through the system. Both expressed similar concerns to Area 1 participants, that individuals are not “flagged” and recorded as a potential threat to others.

The Area 2 MHO group viewed learning disability services as more attuned to risk management processes, making it much easier to arrange meetings and reach multi-disciplinary risk management decisions. Area 2 CMs emphasised the importance of

social workers being very assertive in highlighting risk issues which required intervention. CM37 noted that where someone appears to be able but is making irrational decisions “it is really quite scary”. Several Area 1 MHOs argued that risk processes help to address, but not predict risk. There was disagreement between planning officers CM16 and CM14 over the clarity of Area 1’s risk assessment policy, whereby CM16 asserted that the risk assessment policy was very clear, but CM14 who had recent practice experience, argued that it is much more about “perception”. She noted that “I have tried really hard in my practice not to be risk-averse … I think that is very difficult in our current culture”.

4.5.2.3 Impact of others’ attitudes to risk

Perceptions about the impact of police and prosecutor’s views were examined in the previous sub-section on process. An isolated view expressed by MHO45, neither challenged nor supported by others, was that MHTS were more interested in risk to others than to self. In a discussion about the impact of regulators and national bodies in the Area 1 MHO/CM group, CM7 observed that “we did not do formal risk assessments” but following a Social Work Inspection agency (SWIA) report identifying inadequate or missing risk assessments “we have been told to do a risk assessment on everybody”. Others agreed that following adverse incidents there was often an over-reaction leading to quick and unreasonable change. To apparently unanimous agreement in the group MHO4 stated: ”There will always be tragedies however much legislation and training that we have … it is always the fault of the local authority, it is never the fault of anybody else”.

An Area 2 MHO, supported by several group members, echoed in other groups, criticised unreliable risk assessments from referrers, asserting that risk management

systems do not work, so workers make their own safety arrangements. MHO25 put it thus: “I work with different teams the different workers say this person is really unwell and you go there backed up to the hilt with the police etc and you go there and they just open the door and let you in, yet there are other times when you are told there is no risk and you go in and it is much worse”. In mitigation MHO25, supported by MHO18, noted that “assessment is only as good as the time you do it, because people change, especially with mental health problems people can be very up and down, it is hard to assess the risk”.

Several groups commented on pressure from families and carers to intervene: “well the family is wanting something done straight away ...you need to stop my mother drinking and you are like well you know you just have to run with it” (MHO18). Linked to this, CM22 from Area 2 highlighted similar pressure from management at times. Others strongly agreed CM24 noting that “as a worker you are not persuaded to intervene, but sometimes it has come from way above and it has kind of trickled down to your line manger that you must do something with this case and you almost feel pushed into a corner”.

Area 2 CMs viewed hospital staff as risk-averse, often attempting to prompt relatives or social work to place people in care. District nurses apparently dealt with risk better than hospital-based nurses, a few asserted that nurses are more risk-averse than social workers. MHO19 noted that “some workers (nurses) are less inclined to try and manage the risk and are more likely to just arrange for someone to go into care rather than arrange a care plan at home”. In a more positive light, CM24 asserted that joint working challenges “medical models”. She added that “the hospital is a

disabling environment you know, they don't see how people can manage at home". This was reinforced by one CPN (CM29) who added "people are cared for and have no independence". Two team managers in the Area 1 MHO/CM group suggested that views on risk can be harmonised by meeting and discussing case based issues. Several Area 2 hospitals apparently attempt to support risk management at home, by leaving hospital beds open for people on trial home leave.

MHO25 expressed the view that GPs were frequently indifferent to risk, noting that "GPs are quick to pass the buck and point the finger, but when they needed a favour ...to go out and see somebody, they are more receptive to giving you information about the patient". CM26 agreed strongly, citing situations where she had to pressurise GPs about patients with mental health problems, paraphrasing a typical discussion thus: " 'oh this is nothing to do with us' – and we are going 'no no you are the GP you have responsibility' but I was told by a GP this week 'you are just passing the buck – it is your patient as well' … that was his words".

Several Area 2 MHO/CM participants suggested that the 2007 Act is used to demonstrate that staff are responding positively, rather than any genuine need for intervention "a kind of watch your back and issues of accountability" (CM22). In discussion MHO27 and CM23 highlighted potential risks arising from managers, anxious to avoid public criticism, pushing legislative solutions. Area 2 MHOs saw this as "back-covering" suggesting that risk assessment was "comforting for management, I think it is a bit of a holy grail" (MHO18).

4.5.2.4 Risk thresholds

Underpinning the aforementioned attitudes to risk are individual and professional risk thresholds. Strongly backed by others, CM29 highlighted problems around differing thresholds, noting that where one professional accepts a lifestyle choice, another may be less happy to tolerate this. CM29 characterised the latter view as: “why haven’t you done anything – what about your duty of care?”. MHO25 added that the problem gets worse if the service user is seen as a “management problem”. MHO20 referred to “managing the manager” whereby it was necessary to explain risk-taking and provide reassurance, though MHO18 advised caution, reminding her that sometimes it is the manager’s role to say “enough is enough”. Indeed, many Area 2 participants viewed medical staff and carer’s thresholds for risk as more problematic than their own management, who were generally perceived as quite supportive.

In relation to management risk thresholds MHO4 based in Area 1 older peoples’ services commented: “I have had two different managers in the last year and the difference between one and the other as to what should be an adult protection case conference varies dramatically – it is not even … set in stone when you should have one … it very much depends on the manager”. Area 1 CMs agreed, supporting a colleague who asserted that “the grounds seem to be really unclear about having an ASP case conference and it is bordering into that kind of area where people ... have convened an ASP meeting based on really dodgy value judgements about this individual’s life” (CM15).

Discussion in the Area 2 MHO/CM group concurred that 2007 Act risk thresholds were unclear, but additionally noted that across the legislative framework something had to go badly wrong before intervention was possible. MHO25, looking at Victor’s

case, graphically stated that “prevention” would be preferable to going “in with the big guns”. MHO27 highlighted the significance of the adults’ own views about the risk that they face: “we are led by the service users themselves and what they want and this leads to quite a high level of risk for ourselves at times, not just physically but in accountability”.

MHO18, an Area 2 team manager, cited complex dynamics within intra-agency risk thresholds. She asserted that CMHTs are less risk-averse than other adult care teams, but that most adult care workers have much lower risk thresholds, than child care workers. In Area 1 CM14, from learning disability services, was very clear that the thresholds were generally much lower for CLDNs, particularly where there are risks to others: “CLDNs just want them locked up simple as that” noting that “there has always been a difference of opinion between medical colleagues”. CM47, a social worker, thought her profession made poor use of evidence to assess risk and views differed on levels of risk aversion amongst CPNs.

Area 2 CM/MHOs generally agreed that psychiatrists’ thresholds for intervention are lower for self-harm than for self-neglect, citing examples where self-neglect was viewed as a lifestyle choice, not meriting intervention. The Area 1 CM group similarly reported dilemmas and complex dynamics around lifestyle choice, capacity and risk. Several Area 1 CM/MHO participants argued that the threshold for medical involvement was based on diagnosis. A learning disability worker stated that psychiatrists have a very high tolerance of risk: they “don’t really worry about risk even if we feel it is high risk, they won’t really treat things as urgent so we just have to wait” (MHO20). CM37 in the Area 2 CM/MHO group identified similar anxiety,

whereby concerns for a service user's well-being are dismissed on the grounds that the service user is exercising a lifestyle choice: "that is when you have lack of sleep at night and you are just waiting on the phonecall". CM38 agreed stating "you are waiting on a crisis you know they have got to assault someone to then come into hospital…family are crying out for help...but my hands are tied...until the consultant makes a decision".

Referring to consultants in general medicine's attitude to risk where people were living at home in difficult circumstances CM31 commented: "very often … they will sit on situations for quite some time …before they will agree to … admission to hospital". Participants suggested this was because they were not accountable if things went wrong, though CM35 countered that people often do not meet the criteria. However, in Drew's case she acknowledged differing thresholds for consultants might depend on their knowledge of the patient.

Area 2 participants reported that "Old age consultants" frequently refuse to intervene, on the (disputed) grounds that patients were making lifestyle choice. Furthermore, despite evidence of incapacity and the need for longer term intervention under the 2000 Act, these consultants reportedly resisted hospital admissions, even those at significant risk of harm, to avoid "bed-blocking". CM23 went on to pose the unanswered question: "just because you are over 65 does that mean you are not vulnerable?"

A few Area 2 participants viewed financial thresholds as higher than welfare ones, whereby care managers were reluctant to disrupt family relationships on the basis of

alleged mishandling of money. As CM24 put it, where service users evidently have no money, despite high rates of benefit: “where is that money going? We don’t ask”. Area 2 MHOs noted that even if social workers believe risks are manageable, commissioning services from agencies who have lower risk thresholds can be problematic. The Area 2 CM group similarly highlighted conflicts arising from disagreement about risk assessments. One participant asserted that other agencies make decisions based on partial information and value judgements. CM31 agreed describing a GP who, rather than provide District Nurse support, referred a woman who was not managing medication, for care home admission, thereby handing responsibility to social work. CM31 and CM36 (both nurses) agreed that in such scenarios it was necessary to assert your own views very firmly.

4.5.3 Discussion

There was considerable agreement about risk factors, between different staff groups, though there were significant differences about how to respond, particularly in terms of legal measures. The discussion sheds light on the credibility of the framework from participants’ perspective, by examining perceptions of how law facilitates decision-making about risk and whether it helps to achieve the desired outcomes for service users. In terms of interpreting the law, influence of others and the impact of participants’ own professional and personal values about risk are considered. Perceptions about the evidence base for law, in the context of managing risk, are also explored. A brief discussion on specific risks identified by participants in the case studies is presented at the outset, followed by a detailed discussion of wider findings in relation to risk, linked to the areas noted above.

4.5.3.1 The case studies

Victor

This case was designed to elicit views on use of the 2003 Act to detain older people in hospital, use of the 2000 Act to underpin care arrangements and any impact of 13ZA in that regard. The question on risk sought to establish commonalities and differences in perceptions around the risks associated with Victor and the level of priority these would attract.

The MHO/CM groups articulated several risks and concerns about ethical matters, such as deprivation of liberty and taking into account Victor's own views. This demonstrates awareness of recent debates about 13ZA (albeit several participants could not define or identify 13ZA), and of the 'principles' which require persons acting under the legislative framework to take into account service users' and carers' views.

Some CM group participants were concerned that Victor's allegations about people stealing from him were seen as signs of illness and not taken seriously. Several MWC reports identified similar failure to give credence to concerns expressed by people with disabilities or mental illness (MWC 2010b; 2008b), or indeed to take their views into account. The potential to disregard Victor's wish to go home, and questions over whether he understood his options anyway, were common concerns in the CM groups.

Within MHO groups discussion on risk focused on diagnosis and the impact of inappropriate care. This reflected an understanding of the impact of institutional thinking on patients' capacity to develop and live independently, following lengthy hospital admission (Weinstein 1982; Goffman 1968). Given the rights focus of the MHO role, it was surprising that more was not made of Victor's right to be heard and for his views to be respected. Indeed, the strongest advocates for Victor's rights to exercise personal freedom were health-employed staff in Area 2, somewhat challenging assertions that health staff prioritise medication and control (Rogers and Pilgrim 2001). None of the groups particularly focused on using legislation to manage risk for Victor, largely favouring informal means, whether in relation to diagnosis and treatment or the provision of care and support.

Harvey

The Area 1 CM group reflected Titterton's (2005) ideas about 'safety-first approaches', asserting that medical professionals routinely kept people on anti-epileptic and other medicines for very lengthy periods without review "just in case". CLDNs in the Area 2 CM group focused on risks associated with inadequate sources of support, risk for the parents and risks of misjudging potential for involving Harvey and his parents in decision-making. There was a strong sense of potential negative consequences for family relationships, if legislation was used. This seemed to reflect debate around the attitudes of legislators in several US states and Australia where the focus of law was strictly limited to dealing with the risk of harm to others, thereby avoiding the danger of paternalistic approaches (Atkinson 2006; Greig 2002; Hiday et al 2002; Bean 2001). Nevertheless a few participants emphasised the risk of not using law, thereby compromising Harvey's right to treatment and protection (Campbell and Davidson 2009).

The MHO groups were very focused on ‘over-protectiveness’ by the parents (highlighting the, paradoxical, current failure to protect him), issues of capacity and undue influence. As with Victor, MHOs sought clear medical opinions about mental state and capacity and several referred to there being ”considerable risk” for Harvey in his present situation. This emphasis led to more discussion on legislation amongst MHOs, indicating they were more comfortable than CM groups in using legislation in such circumstances.

The MHO/CM groups reflected mixed views, Area 1 placing the strongest emphasis on respecting Harvey’s views, and use of advocacy. All these groups cited risks in relation to medication and many participants across the groups reflected on potential negative consequences of legal intervention. Risk issues around poor decision-making and assessment of capacity were also expressed.

Agreement was broad across the groups about risks arising from use of the legal framework, and that less interventionist approaches, should be sought first. Participants were anxious to find informal solutions, through processes of negotiation, education and communication. The literature sourced did not address differences between staff groups on these matters, but there was evidence that MHOs may be quicker to use legislation in such cases.

Drew

Drew’s case evoked the strongest responses from most participants. The language was decisive, often punitive and the assessment of risk was almost invariably high. CM groups emphasised the need to get Drew “off the streets” and to ensure a robust

response, some citing the tendency to “under-react”, in their experience, in similar situations. The risks of premature discharge from hospital, if he were to be admitted, were also highlighted. Area 1 CMs highlighted a similar case locally where robust responses were not taken, resulting in tragic consequences. Two MWC inquiries reflect similar concerns: Mr N (MWC 2012f) killed himself whilst on pass, days after being placed on a hospital-based CTO and Mr F (MWC 2009d) was released from hospital and went on to kill his father despite known, significant, risks. Participants’ views echoed Government priorities expressed in the MOP (Scottish Government, 2010e), the CPA (SWSG 1996) and inquiries such as Mr L and Mr M (MWC 2006c), all of which exhort mental health services to undertake robust risk assessments, utilise in-patient care as appropriate and ensure properly constructed risk management plans are established for MDOs, whether on release from hospital or in the community.

Area 1 MHOs identified ‘over-familiarity’ with Drew as a possible reason for inaction by police. Area 2 MHOs also highlighted differing risk thresholds of consultants, depending on their knowledge of the patient. This strongly echoes several MWC reports (MWC 2012f, 2010c, 2009d) which identify situations where staff were familiar with, and in some cases very much liked, the patient and thereby were ‘too close to see’ what was actually going on. In discussing thresholds for prosecution, Area 1 MHOs added that social work was invariably left to manage the consequences, if charges were not pursued, and blamed if things went wrong.

Generally, MHOs alongside the Area 2 CM group, which included several NHS staff, focused on the culpability element and how far Drew could be seen as acting

'knowingly' or whether his actions might be driven by mental illness. The debate reflected ideas from Bean (2001) and Prins (1995) around culpability and consequences, whereby the importance of ensuring someone like Drew was made aware of consequences and others would be aware of his background. This was only possible if there was a proper paper-trail related to criminal charges, rather than just hospital admissions (whether informal or under civil law). Even where police and prosecutors pressed charges, it was pointed out that sheriffs often dismiss cases on the grounds that the individual is disabled.

The mixed groups' focus otherwise was generally similar to others, though many identified potential risk *to* Drew from others, should he overstep boundaries or prove to be a "nuisance", as one MHO put it. While many participants identified risk in the escalating nature of his behaviour, the Area 3 mixed group queried whether he had killed the bird himself, making a link between cruelty to animals and the risk of violence to others.

All the groups argued for some kind of legislative response to Drew. The nature of this response will be examined more closely in the theme relating to human rights, one section of which examines MDO issues. However, the key finding here is, that from participants' perspective, there was broad agreement about the level and nature of risks identified in Drew's case.

4.5.3.2 The influence of risk processes

Several issues were raised around risk management processes, including the idea that risk assessment was administratively driven. This reflects Castell's (1991) belief that social workers would become 'technicians' of risk and Webb's (2006)

interpretation and application of ideas explored in ‘Risk Society’ whereby market forces and managerial control of risk would replace empowering approaches based on identified need (Beck 1992 in Webb 2006). Managers reportedly placed great emphasis on risk processes, pushing workers towards ‘safety-first’ as opposed to ‘risk-taking’ approaches (Titterton 2005). Participants identified dilemmas between satisfying these demands, aimed at putting the agency beyond criticism, and those promoted in legislation, policy and good practice guides (MWC 2006d, urging positive risk taking approaches. Many participants across the groups suggested that, often quite inadequate, risk processes created blame culture and provided a form of ‘back-covering’ for management, if not for staff. This supports Loxton, Shirran and Hothersall’s (2010) view that risk management processes undermine professional judgement and Titterton’s (2005) assertion that workers feel disempowered to promote positive risk-taking.

Many participants nevertheless believed that formal processes, particularly chronologies, were helpful in providing a more concrete representation of risk which could help manage, if not predict risk. These ideas seemed entirely consistent with several writers examined in the literature review, who question the validity of risk prediction tools, but highlight the benefit of robust risk assessment and management processes (Loxton, Shirran and Hothersall 2010; McLean et al 2008; Titterton 2005). Given that experts in literature and participants in this study believe risk prediction is challenging, criticism of health and social work for not anticipating risk, in several MWC inquiry reports (2016a; 2014b; 2010c; 2009d; 2009c) seems unreasonable.

Participants reported strong emphasis on risk management processes at policy level, albeit there were mixed messages about use of underpinning legislation in individual cases. Several Participants reported being pressurised to avoid legislation, in cases where they felt it was necessary, or to use legislation, even where this felt too restrictive. This latter approach was most notable in Area 1, perhaps because risk processes become less flexible following major inquiries (Reith 1998).

4.5.3.3 The impact of risk thresholds and views of others

Participants frequently referred to the impact of others' actions and risk thresholds on their own ability to intervene, though were less reflective on their own particular thresholds, which became apparent at times.

Participants identified problematic attitudes about risk amongst colleagues at an intra-agency level. The 2007 Act purportedly attempted to raise the profile of adult protection to that accorded to child protection (Mackay et al 2011), yet paradoxically several participants reported that children's services tolerate enormous levels of risk before intervening, particularly when compared to learning disability services. Risk averse attitudes towards people with learning disability are certainly reflected in the Borders Inquiry (SWSI 2004) and several MWC inquiries (MWC 2012g; 2009c; 2008b; 2008c; 2006b).

Many participants reported that informal carers had a low tolerance for risk and unrealistic expectations of the capacity of services to intervene, consequently believing that their concerns were often ignored by the services. Such conflicts were poignantly highlighted in the Ms Q inquiry (MWC 2009c) where a presumably well-intentioned parent's actions in response to feeling ignored, led to very negative

outcomes and poor relationships with and between services. Nevertheless, many participants emphasised that relatives did often have to await a serious deterioration in circumstances before action could be taken, one expressing particular concern that failure to intervene might result in tragic consequences. Principles of all three Acts clearly direct that relatives' views, including their views about risk, should inform legal interventions, but as one participant noted if the criteria are not met, the law cannot be used. Whilst it is true that authority to invoke legislation lies with specified professionals, wide-ranging individual and professional risk thresholds influence willingness to use legislation.

Many participants commented on dilemmas arising from their professional duty to promote self-determination (SSSC 2016), reflected in the legal principles of this framework. They were comfortable about imposing restrictions where service users' behaviour caused serious concern or risk to others, but were much less so where service users were prevented from taking informed decisions about risk, due to risk-averse attitudes of professionals. Although one Area 2 group reported that their managers would back them when it came to risk management, there was little evidence amongst participants that management encouraged positive risk taking, rather the emphasis was on keeping the agency safe. Justice Denied (MWC 2008b) demonstrates the pressures faced by managers which may explain this attitude. The local authority is severely criticised for not protecting Ms A from harm in sexual relationships, yet the report acknowledges that at times Ms A engaged in sexual relationships, which were safe. Whilst recording may have been poor, it appeared workers were attempting to adhere to such principles of self-determination.

The 2007 Act is where management wields most influence, coincidentally (perhaps) the one where MHOs have least involvement (MacKay et al, 2011). Participants reported significant management involvement in decision-making processes and wide variation in management thresholds around adult protection issues. Many Area 2 participants expressed concern that the 2007 Act is invoked to protect the agency, rather than because it is actually needed, made possible by lack of definition over criteria for adults at risk of harm (s3) and local authority duty to make inquiries (s4). Remarkably little guidance is provided in the Code of Practice (Scottish Government 2008b) for several key terms in these sections, such as 'risk of harm', 'mental infirmity', 'vulnerable' and 'make inquiries'. This may have some bearing on local variation in use of the 2007 Act and its credibility in the eyes of practitioners. It appears that local authority management have more influence on use of the 2007 Act than the actual criteria and, importantly, there seems to be little agreement as to exactly which risks this Act should address. For example, even amongst this knowledgeable group of participants, a few incorrectly perceived the Act targets harm from others and excludes self-neglect or self-harm.

Management attitudes to risk and use of the 2000 Act were also influenced by perceptions of carers, medical professionals and police. Despite evidence that people were not coping at home, or were being exploited in some way, without supporting evidence from medical professionals or police it was not possible to invoke guardianship or other measures deemed necessary and managers were consequently less likely to encourage pursuit of these approaches. This illustrates how legal measures can be open to interpretation and how decision-making, in a

field where MHOs are thought to have considerable autonomy, can be affected by others.

Care managers highlighted another dynamic in relation to finance and welfare where financial abuse appears to have a lower priority than welfare when the perpetrator of financial abuse is a family member. The complex relationships between regulatory bodies and local authorities may not be helping here. The MWC deals with welfare and mental disorder, not finance, the OPG deals with finance and incapacity and local authority is responsible for all aspects of a person's well-being, yet has very limited powers in terms of finance. Again local authorities are criticised when things go wrong (MWC 2012h) and according to participants have limited backing from the OPG when it comes to investigating or acting.

In terms of the 2000 and 2003 Acts participants repeatedly cited examples where care managers or MHOs have concerns but are left feeling vulnerable, particularly when medical staff, actively withhold their support for interventions. MWC reports seem to attribute slow responses to social work services, whether in the above noted Mr and Mrs D case (MWC 2012h), the Mr A inquiry (MWC 2012j) in responding to an older man in the early stages of dementia or in the Mr H case where social work did not invoke the support of psychiatry with sufficient speed (MWC 2006b).

In other investigation reports criticisms were levelled at health *and* social work agencies for failing to act to protect people, or to consider robust risk assessments, where police and/or medical staff believed the person to be making 'choices' yet the consequences of these choices had serious repercussions. These included Mr F

(MWC 2009d) who eventually killed his father, Mr Q (MWC 2009c) who carried out serious assaults and Ms Z (MWC 2010c) who killed herself. In the focus groups participants repeatedly reported that their ability to intervene was compromised because medical staff, as gatekeepers to the legislation, identified the source of risk as lifestyle choice rather than mental disorder and refused to support applications. Neither the MWC reports nor prominent research studies seem to examine this dynamic in legislation, albeit that some of the texts considered did focus on the impact of differential decision-making based on professional background (MacKay et al 2011; Davidson and Campbell 2010).

Difficulties engaging the support of police, procurators fiscal and sheriffs to prosecute people with mental disorder, who commit crimes and may pose risk to others, were identified across all areas, mainly by MHOs. MHOs seemed more involved in advising on difficult cases, or were involved in civil detentions, where sometimes in their view, criminal prosecutions would be more appropriate, reflecting doubts explored in the literature about the justification for by-passing criminal justice processes for MDOs (Bean 2001; Buchanan 2000). The Millan report (Scottish Executive 2001c) and MacLean Committee (Scottish Executive 2001a) sought to ensure that the 2003 Act took greater account of MDOs resulting in considerable expansion of processes, if not actual measures. The very detailed Code of Practice Volume 3 (Scottish Executive 2005f) and the MOP (Scottish Government 2010e) sought to underpin these new approaches. However, it appears from this study, and many MWC inquiries (MWC 2009c; 2008a; 2006c), that the interface between mental disorder and criminal justice remained problematic prior to the revised MOP (Scottish Government 2010e) and there is no evaluative literature as to how the

revised procedures have improved matters. Most participants, including MHOs made more reference to criminal law or to use of civil measures than to the more complex MDO processes. It appears that many who could, or should, be regarded as offenders are treated informally and are neither held to account, nor identified as high risk in any systematic way. This is an area that would benefit from considerably more detailed research, discussed further when considering human rights aspects.

The seemingly isolated view of an Area 3 MHO that MHTS is more interested in risk to others was surprising, as it is clearly not written into the 2003 Act. In general terms however, many participants reported a three tiered approach: risk to others is taken most seriously, then risk of self-harm and lastly risk of self-neglect. Several participants across all groups believed that self-neglect, often in their view symptomatic of mental disorder, was frequently seen by others (police and medical staff) as the aforementioned “lifestyle choice”, and therefore not eligible for intervention under any of the Acts. From participants’ accounts public bodies are sensitive to issues such as anti-social behaviour where the consequences are obvious to others, but less so to self-neglect which largely impacts on the individual concerned and is therefore invisible. This tiered approach is neither implied nor explicit within the Scottish legislative framework, though MacKay et al (2011) did identify this tendency when reviewing the 2007 Act.

Reith’s (1998) views on ‘knee-jerk’ reactions to community care tragedies were echoed within many of the groups. This was particularly notable in Area 1 where following a negative SWIA report heralded changes in attitude, formal risk assessments which had never been done, were being undertaken with everyone.

Although probably an exaggeration, it was emphasised that many assessment documents now require specific risk-focused statements to be made by the assessor to demonstrate compliance with risk assessment processes.

4.5.3.4 Risk assessment: links to law and evidence base

The literature reviewed highlights an increasing preoccupation with risk as the legislative framework has developed, evidenced not least by increasing use of the word itself in the law. However, criminal justice rather than community care aspects of dealing with mental disorder have received greater attention in terms of policy development, through creation of the Risk Management Authority in Scotland, the revised MOP and revival of CPA (Scottish Government 2010e; Crichton and Darjee 2007).

Despite this, few participants explicitly linked risk to legislation or policy intent, indeed many viewed the law as cumbersome, punitive or draconian. Even in relation to the 2007 Act which contains the most explicit references to risk, concerns were expressed about subjectivity relating to the investigative processes and the calling of case conferences. In general terms, whilst MHOs might be expected to have the best understanding of the issues around use of law and rights, CMs demonstrated significant insight into the complexities of managing risk, decision-making and protection. MHOs were nevertheless much clearer about legal processes and tended to be more procedurally, than ethically focused, when considering use of law to manage risk. The preconceived idea that MHOs would be more attuned to the law as stated in the rationale was to some extent borne out in this study, but the case studies demonstrated subtle differences between MHOs, and between MHOs and

CMs, perhaps attributable to individual characteristics, personal risk thresholds or value base rather than professional grouping.

Many participants believed, like Webb (2006), that there was little evidence base for much of the risk assessment “industry”. Despite one Area 1 planner’s assertion that there was a very clear risk assessment policy in place, other participants disagreed, arguing that it was impossible to be so clear-cut about risk. One-off assessments were widely viewed as unhelpful in reflecting the dynamic process of risk, particularly for those with mental health problems. This has particular resonance for the legislative framework, whereby doctors assessing risk in relation to capacity for guardianship applications (2000 Act) or in relation to detention under the 2003 Act, need only see the person once. Caseholders have limited roles in such assessments yet are likely to be more aware of the person’s circumstances, for example understanding their ability to follow through decisions. Here at least participants and the MWC were in agreement that assessment of capacity should be a multi-disciplinary activity (MWC 2008b).

4.5.3.5 Concluding thoughts

The literature highlights the complex, and at times controversial, nature of risk assessment and management, very much reflected in the debate amongst participants, for whom these issues were clearly of great importance. The view, that risk has replaced need as the arbiter for the provision of services (Loxton, Shirran and Hothersall 2010; Titterton 2005; Levitas 2000), potentially over-simplifies matters. Many participants referred to lack of resources to address risk, a key factor in risk-averse decision-making according to Campbell and Davidson (2012), and to the apparent over-involvement of management, where negative consequences for

the organisation were possible. Dissonance was apparent between government policy, which promotes high quality, systematic risk assessment and reported local practice, based on a much more pragmatic approach. Despite the detailed statute and associated guidance, participant's primary influences relating to assessing and managing risk were rather more subjective, based on internal bureaucratic processes, resources, individual perceptions of risk or fear of being blamed when things go wrong. There was little discussion about the evidence base for dealing with risk, and the usefulness or otherwise of this framework, in assisting staff to manage risk, was unclear. Local variation in use of the framework could be partly attributed to differing thresholds and attitudes, particularly amongst the gatekeepers, predominantly medical staff in the case of the 2000 and 2003 Acts, local authority managers in the 2007 Act and police, prosecutors and medical staff in relation to MDOs. In terms of justification for compulsion, the fact that participants identified a range of thresholds suggests that in itself consideration of risk is only one of a number of factors to be considered, alongside benefit, least restriction and respecting human rights for example. A few felt some of the processes, particularly the 2007 Act investigations did empower local authorities to intervene at times where this would not have been possible before. Few participants mentioned capacity to manage risk when considering the overall credibility of the legal framework.

4.6 Theme Four: Carer involvement

4.6.1 Introductory thoughts on links with the research question

In this section the term 'carer' refers to relatives or friends (rather than professionals or volunteers) who provide direct support to anyone subject to this legislative

framework. Carers have specific rights and responsibilities, under each Act, depending on their relationship with the adult.

Although the case studies included carers, specific questions were not asked about their role, so the importance of this theme only became apparent on analysing the data. Issues about carers are highlighted under other themes where appropriate, for example the previous section reflected on carers' attitudes to risk. This section reflects emergent issues directly focused on carers including: perceptions about legal duties and powers, the nature of support provided to and by carers and on negative impacts carers can, at times, have on interventions.

This study, and the literature reviewed, emphasises that the influence of carers on this legislative framework is of considerable importance. Social work and other agencies have statutory duties to support and involve carers under this framework and other legislation including the Carers (Recognition and Services) Act 1995 (the Carers Act). Carers can exercise a range of functions including Guardians, Attorneys, Named Persons or primary carers. In terms of credibility of the legislative framework for participants, the discussion will examine how far the legislative framework assists workers in meeting their duties towards carers and in turn helps them to support service users. As has already become apparent participants were anxious about the impact on carers of using legislation and, in the Victor and Harvey cases, fears were expressed that legislation would alienate rather than support carers. Participants' interpretation of the law as it affects carers might therefore impact on their willingness to invoke legal measures. Wexler (2000) suggests that the effectiveness of involvement and empowerment for service users and carers is a

benchmark against which the efficacy of the legislative principles might be measured.

4.6.2 Findings

The findings are loosely grouped around the aspects highlighted in the introductory paragraph, namely the role of carers, issues around support and dilemmas for social work staff in relation to carers.

4.6.2.1 The role of carers

All areas were quite clear that with regard to the 2000 Act, the default position would be that family members would act as proxies. In the Victor case study, MHO2 from Area 1 stated that this "reminds me of a number of cases where I have been involved" going on to say that Area 1 would expect the family to be guardians "unless there is reasons why they wouldn't individually" or jointly, most seeing a joint guardianship between the son and daughter as desirable in Victor's case.

In Area 2 there was more emphasis on the local authority as guardian. It was suggested that carers might be deterred from applying because of process issues: "it is a big thing for the family to have to go through the lengthy application processes especially at that time (when a person with dementia is refusing to move into care)" (MHO19). Another participant agreed stating: "I mean we are used to legislation" (MHO20). Similarly, an Area 3 MHO noted when supporting carers in their role as guardian "at different times I've taken up this wodge of stuff ...the roles and responsibilities of the guardian and tried to explain that to people and it just confuses the life out of them" (MHO41).

Various cases were cited where guardianship powers could potentially be misused. In Area 2, MHO21 expressed concern that empowering parents, as in Harvey's case, might lead to difficulties in challenging their authority if there is disagreement. In Area 3 a case was cited where a man, already in residential care, expressed the "capable" view that he did not want his "incapable" wife to move into the same care home. Their children intended to ignore this view, but the local authority intervened and took out guardianship to move her to a different home. MHO17 in Area 2 described conflict between joint attorneys when a service user was behaving aggressively in a care home, and a move was required. She explained it thus: "there is massive disagreement between the attorneys ....at the time (of the initial move) it was fine but when a big decision is needed there are difficulties – one person can be quite understanding about (the problem of) ...aggression and violence in the home setting...but the other is not really taking the issues on board".

Area 1 MHOs noted that relatives were un-necessarily applying for welfare guardianship, because solicitors had advised them to do so, at the same time as applying for financial guardianship, to enable costs to be offset by legal aid. Groups in Areas 1 and 2 debated the legality of appointing guardians who lived abroad and interpretations around the requirement that guardians are "available" to the adult.

4.6.2.2 Issues around support

MHO20 identified potential use of the Carers Act to provide support to Harvey's parents "maybe if they got that help then that might help them to recognise Harvey's needs". She also asserted that carers needed support to understand and assume roles under the 2000 Act. Differing views were expressed in Area 2 as to whether the parents should be supported to work with Harvey or not. Area 2 and 3 MHOs

were more inclined to view their influence as negative. However, CMs generally, alongside Area 1 MHOs, hoped education and support might help carers better understand Harvey's needs around medication and finance. The Area 1 MHO/CM group suggested that lack of support to Victor's son, might cause him undue stress and impede his ability to discharge his powers as an Attorney. This same group also questioned whether Harvey's friends might be providing valuable support despite the apparently exploitative element.

CM34 asserted a community placement will not work if the "son (in the case of Victor) is going to be going behind your back … scuppering it for you". CM31 agreed noting that 'if the family aren't in agreement with our decision to put people back to their home...if the family are undermining you it gets quite hard'. When asked about possible solutions, family support was raised by CM35, a CPN: "not looking at any of the Acts...there may be a bit of family work ...in some respect the son and daughter (of Victor) are at kind of opposite ends so there may be some work to be done". Area 1 CMs, echoing this view, suggested core social work skills could be key to resolving conflicts, though law might be used to encourage cooperation "you can kind of bring it into the conversation to let people be aware what your responsibilities are as a council officer on these cases – that is sometimes enough" (CM15). CM13 agreed, observing that "the ASP route is quite a blunt instrument to resolve complex dynamics within the family … I need to be freed up … to use my social work skills to engage with that family and … time to really get to the root cause of what some of the risks are".

4.6.2.3 Dilemmas around negative influences of carers

CM24 cited problems with conflicting values: “it’s often not the person that is the problem it is the relatives”. The Victor case provoked discussion around such issues within the Area 1 MHO group. MHO3 cited cases where relatives, have acquired power of attorney, seeking to admit someone to care but “it is really dodgy and it was done two months before you got involved and it is clear the person did not have capacity at the time”.

There was debate across the groups over conflict between carers and professionals and the correct course of action. CM13 in Area 1 described a situation where he worked with an older man who was deemed “capable” but described “warring and conflicting statements … coming from family members – you know I am going on what the man is telling me because he has the capacity to do that ...it is dealing with the contradictory demands of the family whilst realising that my concern is the welfare of the older man”. He described efforts to use the 2007 Act to resolve some of the issues, whereby one family member wanted a banning order, on another she claimed was exploiting him. This was further complicated because, the police refused to become involved, because in their view the man was “technically capable” and should therefore have been able to make a complaint. However, CM13 disagreed, judging that he met the criteria for adult at risk of harm (s3 the 2007 Act).

MHO2 in the Area 1 MHO group also expressed anxiety about being caught in the middle, whether in objecting to specific measures in a guardianship application or “taking sides” where one person has applied and another family member is challenging it. He described this as a “very uncomfortable place to be”, noting that social work is being “sucked into these family things for a variety of reasons ...getting

into really difficult areas … that process can take the family to the edge". MHO3 agreed stating that "the process can magnify divisions rather than ameliorate them". Both agreed MHO skills were more likely than legislation to resolve such issues.

Many participants were concerned that powers, or even informal means, were used by carers to "line their pockets" to the service user's detriment: "Relatives are cashing their pensions and maybe sometimes it is difficult to get money out of them, … sometimes we were begging for money from them to buy clothes or something ... and you were never getting any money out of them" CM22 (a nurse working with older people)

4.6.2.4 Dilemmas around use of legislation and providing support to carers

Widespread concerns were raised over how using legislation might damage relationships with carers. In Area 3, MHO41 described a similar case to Harvey's where his parents were still looking after him at the age of 68 and still shaving him, asserting that they have infantilised him, yet with the best possible intentions. He emphasised that this man's mother was doing an amazing job and that when he was born "medics and everybody were saying to her just forget about him and put him in an institution". He characterised a discussion with the mother thus: "now you are telling me I have to apply for these powers that I have always had ...what right have you got to tell me that I have got to do that, when I was looking for help you were not there". This scenario was recognised and echoed by other participants. MHO43 added that there is an alternative narrative, which can also be difficult to deal with, whereby people recognise that they can no longer cope and the approach to services is more like "I am getting on and I want all these plans signed, sealed and delivered now!"

The Area 2 MHO group reflected on other over-zealous approaches to well-intentioned carers. MHO20, who worked in learning disability, commented that “a lot of parents want help but are unable to articulate it and then we … walk in and … trample their rights”. MHO18 commented in respect of Harvey’s situation: ”there is a balance between the role of the parent in looking after him and his rights to self-determination – you can’t just go in there and totally disrupt all those years of caring … it would be using a sledgehammer to crack a nut”. With reference to ageing parents caring for their sons, MHO3 commented “we ought to be grateful to them”. This was in response to MHO5’s comment about Harvey that “we can offer very little” as there are no day centre places available in Area 1 and direct payments have been frozen.

MHO10 in Area 1 revealed that where middle managers had previously been responsible for supervising guardians “practitioners have been asked to take on supervision of guardians and review guardianships without really knowing what that involves”. Participants in other areas undertook supervision as a natural extension of the case-holder role.

4.6.2.5 General points

There seemed to be almost unanimous agreement across the groups and areas that where conflict arose between carers, legislation was rarely likely to resolve things so informal support and use of social work skills was much preferred. However, local authority intervention by means of legal powers such as guardianship, was viewed by most as being better than trying to force relatives to manage conflictual joint guardianship or attorney arrangements. Area 1 CMs when considering issues

around minor financial abuse by relatives highlighted the lack of flexibility in the 2007 Act.

4.6.3 Discussion

Although participants clearly recognised the valuable roles carers can play, a surprising level of negativity was expressed about carers' involvement. Perhaps due to political sensitivity about the role of carers, findings such as these were not encountered in literature accessed for this thesis. It is acknowledged that two case studies highlighted potentially problematic carer relationships, but participants described many cases from their own experience which echoed and expanded on these aspects and added issues not alluded to in the case studies. The fact that participants routinely work with highly complex and challenging cases, may also have contributed to the range of problematic cases put forward.

Nevertheless, it is widely recognised in the literature and echoed by participants, that most informal carers play a huge role in supporting people at home and even in institutional care. Carers UK (2011) claimed that the monetary value of informal carer support in Scotland equated to the £10 billion Scottish NHS annual budget.

With these words of caution, the following discussion examines the nature of carers' involvement in this legislative framework, the support carers need to participate and finally reflects on the implications of this for the law as it is currently configured. Underpinning this discussion are reflections on participants' interpretation of the law when applying it and their perspective on the credibility of the law in supporting carers.

4.6.3.1 Carers' roles

All participants seemed clear that wherever possible carers should be supported to care for loved ones. One participant recalled a case where the motives of social work were regarded with deep suspicion, when intervening with a service user with learning disability who was in his 60s and had apparently been cared for adequately by his parents all his life. At birth they had reportedly been advised to admit him to an institution and move on with their lives. Historic attitudes to care and treatment were examined in the early part of the literature review, for the very reason that these may have resonance in the present day. This case certainly could demonstrate how such attitudes can influence present day relationships between carers and care services. Social workers' understanding of the impact of asking service users to substitute a trusted informal relationship for a professional relationship was seen as limited in other studies (Daniel et al 2013; MacKay et al 2011). In this study loss of trust between professionals and families, was certainly identified.

Carers have key roles under all three pieces of legislation, but it was the 2000 Act, which seemed to pre-occupy most participants. Local authority policy, widely supported by participants, anticipated that family members would take on the role of attorney, guardian or as proxy in some other way and local authority would only intervene if there were problems preventing family members from doing so. Unlike the 2003 and 2007 Acts, the 2000 Act enables very wide-ranging powers to be taken on by family. The main part of this discussion therefore dwells on the 2000 Act returning to the 2003 and 2007 Acts towards the end.

Participants noted that when solicitors advised applicants to apply for wide-ranging or 'plenary' powers (Ward 2003), or for welfare as well as financial powers to

circumvent legal aid regulations, this breached least restriction principles (s1, The 2000 Act) and caused mistrust of contrary social work advice. Where proxies failed to understand that these, apparently wide-ranging, powers are limited by the obligation on all those exercising powers to comply with Section 1 principles again there was potential for conflict with social work. Participants were particularly concerned about the potential for undue concentration of power when close relatives acquire wide-ranging powers as proxies. In the review of literature (2.11.1), it was suggested that those exercising power of attorney may be unable to authorise deprivation of liberty, (Patrick 2008; MWC 2007b). Although still to be tested out, this has the potential to further damage relationships with professionals, if carers have at some expense followed advice and applied for powers that are later deemed to be insufficient.

4.6.3.2 Resource issues and support for carers

The review of literature identified many drivers towards de-institutionalisation across the UK (Rogers and Pilgrim 2001; Scull 1996). Several policy initiatives (Scottish Government 2012f; Scottish Executive 2000) have further contributed to the almost complete disappearance of institutional care for learning disability in Scotland and the closure of most remaining in-patient learning disability beds. Despite the insistence of some commentators that financial imperatives are not at the heart of such changes (Coppock and Dunn, 2010), dialogue within the focus groups suggests many participants believe otherwise. Participants identified freezing of direct payments, lack of day centre places and limited alternatives to parental care available to families, highlighting an increasing dearth of community facilities for learning disability. The fact that these groups took place as economic problems began to affect the UK, and before the subsequent spending review (HM Treasury

2010), suggests that this does not just relate to financial restraints, but possibly to unintended consequences of 'The same as you' (Scottish Executive 2000a), whereby so-called segregated services are phased out in favour of mainstream provision. Many participants viewed this as simple cost-cutting and emphasised the negative impact of these cuts for carers.

Similar concerns were identified when considering the role of carers for older people and other care groups. In many cases concerns were expressed around negative relationships based on financial exploitation and precipitate decisions to place people in care. This latter point was examined in some detail in the literature review when considering the potential for 13ZA to undermine the rights of older people who may be unhappy to be placed in care or forced to receive services they do not want.

Concern around limited resources and rights led to considerable discussion in the groups around sensitivity to carers' needs in the context of the protection and developmental needs of service users. Campbell and Davison (2012) cite studies which showed that carers were often dis-satisfied with the exercise of statutory powers by social work, though Rogers and Pilgrim (2001) viewed this as more general dis-satisfaction with mental health systems as a whole. Participants in this study spoke with authority on these issues, because as care managers and MHOs they were often the lead professional telling carers that state intervention is needed and by implication their ability to look after their loved ones is inadequate. Many participants regarded the legal processes as unwieldy and threatening and the resources to provide alternatives to apparently inadequate informal care as seriously lacking.

Carers also at times lacked understanding in exercising powers, according to participants. Unusually in Area 1 private guardians were supervised by middle managers, not the case-holder as was practised in the other two areas. Perhaps reflecting increasing demands created by rising numbers of guardianship and the consequent need to delegate functions, this was about to be handed over to case-holders. Most participants believed supervision of guardians was a natural extension of the case-holder role, however, difficulties were identified in ensuring proxies understood their role. A few participants identified a training gap in taking on this task and others felt they lacked authority to act on identified problems. The Mr Q report (MWC 2009c) in particular highlighted the difficulties when proxies (his mother) exercised powers forcefully, an issue that should certainly be addressed in such training. Rogers and Pilgrim (2001) highlighted conflict between in-patients and their carers where the latter sought measures to contain, conflicting with patients seeking more therapeutic intervention.

4.6.3.3 Issues arising from use of the law

The 2000 Act

Research by Stalker, Duckett and Downs (1999) which prepared the ground for the 2000 Act highlighted mixed views about the capacity of older people to make decisions and reviewed a range of strategies which respected individuals' rights to self-determination, but enabled carers or statutory authorities to make appropriate timely decisions. Good communication and adequate time were viewed as essential building blocks. However, participants in this study identified lack of time to engage effectively with carers, and a tendency to act precipitously, using the law as a shortcut rather than taking time to find less formal means of resolving issues. This

reportedly led to conflictual relationships, ethical dilemmas and underlying problems for the future.

Participants referred to being “sucked into” conflicts between family members, a metaphor which seemed to reflect participants’ perceived lack of power and control over situations. These conflicts were not just between family members, or between family members and social work, but also between carers and service users resulting in complex ethical dilemmas for professionals. A few participants suggested complexity associated with implementing the law, related to such competing demands. Ward (2003) recalled strongly held beliefs amongst those responsible for reform of the 2000 Act, that simplifying processes would help resolve such conflicts. However, evidence from this study and from high profile reports (Patrick 2008; Killeen et al 2004) suggests that, despite streamlined processes and clear guidance, the 2000 Act in particular remains controversial, complex and bureaucratic. Rather than a failure of reforms, this may reflect Webb’s (2006) contention that society expects more in this rapidly changing, ‘post-modern’ age, such that service users and carers will make more vocal and perhaps unrealistic demands. This complexity could however, be overstated, in a deliberate effort to disguise and excuse failure to meet increasing demands. This assertion will be revisited under later themes.

Given the emphasis on carers across the legal framework it might be expected that the law would help resolve issues and support decision-making. Few participants believed the legislative framework helped in resolving family conflicts, though many viewed it as useful in allowing social work to intervene in intra-family feuds as a last resort. It was clear that processes associated with using the law brought about

change in attitudes in a few cases, but more often where the law was invoked the processes could seriously damage relationships between families and statutory authorities. Strong and very negative metaphors were deployed to illustrate these points, one participant going as far as to suggest legal processes were “trampling their (carers) rights”. Many participants believed use of social work or MHO skills, family work and other informal approaches were much more likely to effect change. The later, somewhat limited, Ekosgen (2013) study on the 2007 Act also reflected this negative view of the impact of law on relationships with carers.

Findings in this study suggest that MWC concerns over the failure of social work to address problems with power of attorney arrangements in the Mr and Mrs D case may be over-simplified (MWC 2012h). Participants were alert to concerns over attorneys abusing their powers, but demonstrated less awareness as to how to address this. This probably relates to earlier noted difficulties key staff experience in accessing advice, suggesting a more systemic problem, as opposed to worker neglect. Furthermore, several participants’ concerns were over the granting of such powers, a matter over which they had no control: as gatekeepers to this process are GPs, lawyers and the OPG. The MWC report cited lack of knowledge on the part of the GP (MWC 2012h), but participants described a much more concerning, deliberate collusion, between gatekeepers and unscrupulous individuals.

The 2003 and 2007 Acts in relation to carers

Discussion about the 2007 Act revealed surprisingly negative views about carers’ involvement. Case examples cited focused on abuse and exploitation, often with an emphasis on protection from carers. Despite having ‘support’ in the title, participants reported that the 2007 Act was almost exclusively used to address failures of care or

actual abuse, an issue echoed in later research by MacKay et al (2011). Participants accepted that, notwithstanding earlier reported ethical concerns, investigative powers under the 2007 Act, provide helpful and previously unavailable opportunities to intervene in complex family relationships.

The interface between carers and the 2003 Act largely relates to named person provisions, though s1 principles seek to facilitate support for carers. There was little comment amongst the groups relating to named persons possibly suggesting these measures are regarded positively. However, failure to take carers concerns seriously or delays in acting on such concerns were raised. These issues are picked up under other themes.

4.6.3.4 Links to the research question

There was widespread agreement with the intentions of the 2000 Act, across areas and staff groups, that carers should be supported to seek powers and that local authorities would only intervene if problems were identified or there was no-one suitable to act. Notwithstanding problems about respect for the rights of families and carers, participants believed the 2000 Act contained useful measures to explore complex intra-familial issues, if not to actually resolve conflicts. However, the aspiration of simplifying measures in relation to incapacity (Killeen et al 2004; Ward 2003; SLC 1995) may have only been partially successful from carers' perspectives, as it seemed carers were often unclear as to the nature and extent of their powers. Other themes in this study explore the ongoing problems which have led to repeated, wide-ranging and confusing proposals for reform, ever since enactment of the 2000 Act, which no doubt contribute to this lack of clarity (SLC 2014; OPG 2011; Patrick 2008; Killeen 2008). On the other hand, 2003 Act changes seemed to be welcomed

by carers and, despite reservations about its general provisions, the 2007 Act has enabled participants to intervene with families in a more assertive manner.

The interface between the legislative framework under consideration and the wider law in relation to carers was generally seen as congruent by the few participants who commented and no particular conflicts were raised. The legislative framework does seem to provide opportunities to support carers, even if this does not always achieve the desired outcomes, or the resources to provide support are lacking. It was not clear from participants' responses how they viewed carers' exercise of powers in more general terms, as they tended to focus on misuse of powers and issues of abuse and neglect. This area would benefit from further research, given the emphasis on empowering carers across the framework.

4.7 Theme Five: Diagnosis, assessment and consent to treatment

4.7.1 Introductory comments

Assessment, diagnosis and treatment were initially separate codes arrived at through discussion, but are so closely linked there is value in treating these as one discrete theme. The review of literature highlighted the changing nature of diagnosis over time (Johnstone 2008; Van Os 2003; Shorter 1997; Ward 1990) and in relation to values and assumptions, for example in relation to criminal behaviour (Greig 2002) or gender (Ussher 1991). Consideration was given to underpinning concepts related to assessment (for example incapacity and risk), and to the consequences for treatment and civil liberties (Patrick 2012, 2009, 2008; MWC 2008a; Ward 2007,

1990; Chiswick 2005; Crichton 2000). The review also examined how the law has responded to changing emphasis in these areas (Brown et al 2012; Campbell 2010; Bean 2001) and the impact on service provision (Ekosgen 2013; Kisely et al 2005).

Participants held widely varying views around the nature and quality of diagnosis and assessment, how consent to interventions was determined and expressed strong views about the role of gatekeepers for this legislation. These aspects seemed of crucial importance in judging the credibility of the legislative framework for participants, and shed some light on their interpretation of the various measures contained therein.

4.7.2 Findings

4.7.2.1 Diagnosis

Participants were not involved in 'diagnosing' as such, but were very much responsible for assessment and there is some crossover between the two. This sub-section is therefore very brief, but other sub-sections make reference to diagnostic issues and other themes also examine participant's perspectives on diagnosis.

Looking at the case studies, Area 3 MHOs and Area 2 CMs identified Drew's changing diagnosis as a significant issue. CM36 (a CPN) commented "who has put the label of bipolar affective disorder in there? You find it just appears in someone's notes". An Area 3 MHO suggested that bi-polar affective disorder is "the diagnosis of the day" and another responded "you get files that have more diagnoses than addresses" (MHO5), strongly endorsed by MHO4. Area 2 groups asserted that in Harvey's case, to receive a diagnosis or be eligible for learning disability services his

IQ would have to be assessed as under 70. Area 1 CMs were quick to urge caution about equating incapacity with a diagnosis of learning disability.

A few Area 2 participants noted that people indulging in dangerous self-harming behaviour were not always seen as mentally ill. A case highlighted in Area 1 graphically illustrated this point. MHO1 referred to a woman who was "killing herself, abusing herself horribly" but a case conference concluded she was outwith the scope of the Act(s): "it is on the other side of the line. It is interesting in our society there are those divisions, you know as a society we are a bit all over the place". This was raised in the context of a debate as to whether alcohol dependence should be seen as a diagnosable mental illness.

4.7.2.2 Assessment

Capacity

MHO45, in Area 3, suggested that despite their gatekeeping role in assessing for compulsion or capacity, doctors look for medical triggers and do not listen to the person properly: "so they have to decide if the person is ill enough, so unless you have those nothing happens, no matter what you believe the person needs". Trainers in Area 1 and 3 emphasised the importance of helping staff to develop confidence in their own ability to assess capacity and to challenge doctors: "doctors obviously do the formal tests for these applications - we are all capable of deciding who has got capacity or not and I try to say that to social workers all the time" (MHO4).

CM7 in Area 1 regarded the 2000 and the 2003 Acts as very medically focused: "pretty much a medicalised bit of legislation, unless there is some degree of capacity

stuff, and that depends on a medical opinion...largely...whether you can progress it or not, and that is quite difficult to get". Furthermore, when social workers contacted medical staff with concerns "unless it is blindingly obviously a medical thing, it is a social work issue" (CM7). Area 3 mixed MHO/CM group participants identified similar obstacles to care management involvement in decisions about capacity and Area 2 CMs struggled obtaining "capacity assessments" from doctors, citing an example where a GP refused to visit a person with Huntington's disease to assess her capacity due to past alcohol misuse.

Alcohol

The impact of alcohol, in terms of worsening conditions and confusing assessments, was further explored by the Area 2 CM/MHO group. Situations were highlighted where incapacity impaired individuals' judgement about alcohol misuse rather than simple dependency. CM36 in Area 2 contributed a statistic that "66% of people with bi-polar illness have substance misuse problems", during a discussion on the impact of alcohol on assessment. Similar concerns about the impact of drugs on assessments were expressed by Area 1 MHOs discussing Drew's case.

Lead roles

Area 3 CMs perceived assessment of new referrals under the 2007 Act as inappropriately dominated by management. An access team worker noted: "when the case is new ... much of the discussion is between the service manager and the team leader ... I have felt excluded from the process ... very different to my child protection experience. I feel we should have been much more part of the planning process...where I have actually questioned the three-point test it is already decided and I would have wanted to ask that earlier you know why am I going out under ASP" (CM47).

Area 3 MHO group members valued early MHO involvement in decision-making, citing situations discussed under earlier themes. MHOs are presented with unrealistic decisions, arising from adult protection meetings to which they had not been invited: “they say well the case conference decided guardianship and we say well I don’t care! Look at you in amazement” (MHO43). Another MHO agreed, noting that she often had to explain to care managers, who did not understand the criteria for intervention, why psychiatrists were refusing to support guardianship applications. In the context of Area 1’s policy that MHOs should lead guardianship processes, MHO8 highlighted how social workers felt excluded from assessments: “the social worker is…left there still working with the family and the individual but not really knowing what stage things are at and not really being involved greatly in the process”, though CM13 observed that some social workers were relieved to be excluded from “this legislative, alienating kind of structure”.

Integration

Lack of integration was identified in several domains of assessment relevant to the legislative framework. Reflecting on Drew’s case, Area 3 MHOs commented on lack of discussion about motivation for offending between social work, police and the procurator fiscal when assessing MDOs. Area 2 CMs felt excluded from decisions about medication, despite the need for cooperation in arranging social care or seeking legal interventions. In-patient health services readily left case management decisions about people with personality disorder with community care teams and one participant noted CMHTs in a neighbouring authority refused referrals for personality disorder. Area 1 MHOs, commenting on integrated assessment, believed that professionals remained “in their zone” and did not communicate with others to assist

their thinking: “if people are left alone in their own particular view … it is more likely that something inadequate will result” (MHO1).

Environment

Area 2 CMs, noting that good information enhances assessment, argued that Victor’s assessment would be best undertaken in a hospital setting. A CLDN in this group remarked that Drew would also be better assessed in hospital. The importance of a co-operative approach to assessment with psychiatrists was emphasised. Critical of snapshot, “one-off” type assessments CM35 commented that hospital-based assessments “allowed assessment over a period of time”. One participant’s support for hospital assessment, as a drug and alcohol free environment, was dismissed mockingly by most others. One participant was critical of the hospital environment as the scope for recovery and return to home might be missed, if the individual appeared worse whilst in hospital.

Behavioural issues

Area 2 CMs described how certain behaviours impacted on assessment, partly attempting to differentiate between mental illness and irrational and dangerous behaviours, though there was little agreement around this. Across the groups many participants regarded minor self-harm and small overdoses as the less dangerous end of the behavioural spectrum, but a few Area 2 CMs included people being taken from high bridges or dousing themselves in petrol at the upper end, where most thought this likely to indicate mental illness. Area 2 nurses described individuals behaving “well”, or “badly”, for their consultants to achieve particular goals, related to benefit claims or remaining with, or being discharged from services. One Area 2 MHO noted that someone regarded as intimidating, because of their physique or

their manner, might be assessed as dangerous, even where there is no evidence of threat to others.

Other influences on assessment

Reflecting on Victor's situation, Area 2 CMs illustrated the importance of timing in assessment. Victor goes out for a drink on Tuesday night, so he may happily remain in hospital until Tuesday night, when he becomes very resistant to staying, potentially leading to an avoidable detention. Others in the group identified circumstances where decisions to detain followed a patient being distressed by visitors, stressful events on the ward or perhaps where transient delusions were being experienced.

An Area 2 social worker noted that Victor's confusional state may have a physical cause, questioning whether this would be investigated, or dismissed due to assumptions made about confused older people. Area 1 CMs highlighted actual cases where GPs did not review medications, with side effects. This failure of GPs to review medication or identify physical illness was criticised by participants, as consequent psychiatric symptoms could have been addressed without detention or compulsion. Furthermore, several participants believed failure to take physical illness seriously in those with mental disorder led to unnecessary harm or even death.

4.7.2.4 Consent issues

Informed decision-making

Unquestioning compliance by older people regarding the medical profession was discussed in the Area 2 CM group. CM38 commenting on Victor's case noted he is "of that generation … you do what you are told if you are in hospital if the doctor says you stay - you stay!" CM36 further questioned whether "we accept that because he

is not acting on it or trying to (an expressed wish to leave hospital) that he is actually OK". MHO27 from a different group presented a remarkably similar caricature of some consultants' approach to decisions around capacity to consent: "he didn't say no, therefore he must mean yes". Area 3 MHOs emphasised that Victor may have capacity to decide, if provided with sufficient information to make an "informed" decision. Area 1 CMs too identified this issue, strongly promoting advocacy involvement where doubts existed.

Subjectivity of assessor

Area 3 MHOs cited wide variation in outcomes from different psychiatrists undertaking capacity assessments. Referring to decisions under the 2003 Act, Area 2 CMs described this variation in approaches as indecision: "consultants have different opinions as to 'do we, don't we', as well" (CM35). CM38 observed that absence of shared approaches, following a decision not to detain, left no "back up plan" and the community teams were "left to get on with it". Several CPNs observed that psychiatrists base their decisions on personal knowledge of the patient and that the emphasis of a treatment plan can change radically when a patient has a new psychiatrist.

The Area 3 MHO group broadly agreed that cases such as Harvey's generate widely varying responses from sheriffs. One MHO cited a case of a woman with Korsakoff's syndrome, who, lacked ability in the most basic levels of self-care, lacked understanding of the court process and was in their view significantly impaired. Despite this the Sheriff rejected a guardianship application, based on his own assessment, without reference to medical evidence.

Tied in with the earlier discussion about whether assessing capacity was the responsibility of medical staff or was essentially multi-disciplinary in nature, a few MHOs raised concern that doctors often failed to involve others in medical treatment decisions under s47 of the 2000 Act. Area 1 MHOs challenging the exclusive role of psychiatry in assessing capacity, argued that community care staff were capable of contributing to assessments.

Various reasons for this subjectivity were proposed. The mixed Area 1 group cited lack of training in assessing capacity. One participant raised the issue of thresholds: a person may lack insight into their condition, but "at what level was her comprehension impaired?" (CM48). Area 2 MHOs posed a similar question as to whether someone, like Drew, might therefore be considered to lack capacity if he did not understand the consequences of his actions. The group further reflected on the complexities of assessing capacity, concluding that traditional capacity assessments used by learning disability or old age psychiatry were not fit for purpose.

Expedient assessments

From a different perspective the Area 2 MHO group highlighted situations where a psychiatrist might decide a person had capacity to decide on issues of care: but not in relation to money: "I didn't think capacity was a moveable feast – you've either got capacity or you've not ...it is expedient to say someone has got the capacity to make a decision (about a care home). It means they get moved with the minimum of fuss and no order" (MHO18). This view of incapacity was echoed by an Area 1 MHO "my experience is it (capacity) ebbs and flows according to bed availability" to universal agreement within the group. Similarly, several Area 2 CM participants additionally reported decision-making about diagnosis, speeded up when hospital staff assessed

someone as a “delayed discharge”, a practice viewed as unethical and undermining sound assessment principles and processes.

An isolated, but nevertheless interesting perspective on capacity arose from the MHO group in Area 1 “this term capacity as well I’d never heard of it until about ten years ago this word seems to be bandied about all over the place” (MHO6). This group saw incapacity as a very fluid concept, describing a case where it took a year to get an assessment of capacity on a service user.

Fluctuating capacity

Fluctuating or worsening capacity was highlighted by Area 2 MHOs. It was noted that a person may initially agree to care proceedings, but as the condition worsens consent is withdrawn, requiring an urgent application for guardianship to effect a move. Area 1 CMs also identified this and highlighted the importance of careful, ongoing psychiatric assessment.

4.7.3 Discussion

These findings do seem to shed light on why decision-making is so variable across areas and disciplines and informs, yet also challenges, the evidence base for intervention. The broad headings, under which the findings were recorded, are used to present the discussion.

On a very simple ‘content analysis’ basis (Bryman 2008), it was interesting to note differing emphasis across the groups about assessment, diagnosis and consent. In particular, the transcripts showed a huge interest in these areas in the CM group in Area 2 which consisted of seven nurses and only two social workers. Otherwise

these issues seemed to be more of a preoccupation for MHOs than for care managers.

4.7.3.1 The influence of diagnosis on intervention

Diagnosis issues proved to be a matter of concern and debate for participants, though the line between assessment and diagnosis was somewhat blurred. Despite the ongoing development of ICD 10 and DSM-5, intended to bring scientific rigour to diagnosis, participants' views echoed commentators' criticisms over the reliability of diagnosis (Coppock and Dunn 2010; Johnstone 2008; Shorter 1997). CPN and MHO participants using dry humour, described bi-polar as "diagnosis of the day" and that some people had "more diagnoses than addresses in the case file". One CPN observed that a diagnosis such as bi-polar can "appear" in the notes, with no indication of how, or by whom, this was established.

The review of literature identified a rush to medicalise behaviours (Coppock and Dunn 2010; Johnstone 2008) describing how drugs, such as Prozac, were used as a medical response to social circumstances (Tummey and Turner 2008; Ussher 1992). To some extent participants echoed this view by suggesting that appearance, demeanour or behaviour could unduly influence assessment or diagnosis, but in many cases the opposite picture was being presented, whereby psychiatry avoided treating people presenting so-called behavioural issues.

Participants seemed less confident than some commentators, (Atkinson 2006) that the Scottish legislature had avoided difficulties over diagnosis and treatment of personality disorder evident elsewhere. Indeed, feedback from Area 2 participants suggests that this message has not got through at practice level. Reportedly

psychiatrists avoided dealing with personality disorder, to the extent that a neighbouring authority's CMHTs refused to accept referrals for personality disorder. Aware of the priority afforded to this group by the 2003 Act, participants were critical of this approach.

Problems about simplistic diagnostic tools such as I.Q. still used as a baseline to diagnose learning disability, were discussed across the groups in relation to local authorities' ability to intervene and provide services. Similarly concerns were expressed by many in equating diagnosis with assumptions of incapacity, whether dementia or learning disability. s1(6) of the 2000 Act clearly states that incapacity is about decisions, not about diagnosis, albeit that it must be "by reason of mental disorder or…inability to communicate because of physical disability".

Although some ideas in the literature review were not explicitly addressed by participants, for example around the politicised nature of diagnosis, discriminatory aspects towards women or use of diagnosis to enforce norms (Coppock and Dunn 2010; Shorter 1997; Ussher 1991), it was clearly a matter of considerable concern and frustration, if not of dark amusement for participants that diagnosis was neither seen as straightforward nor based on objective criteria. The underlying point seemed to be that no real care was taken about diagnosis, despite the major impact this may have on whether or not the Acts were to be used or services provided.

4.7.3.2 Assessment: responsibility, accountability and impact

Whilst there was frustration at attitudes to diagnosis, considerably greater concern was expressed about failures in assessment processes. CPNs in Area 2 suggested that assessments were often subjective, based more on personal knowledge of the

patient than objective criteria (such as ICD 10). This reflected serious concerns raised in national inquiries (Reith 1998) and several more recent MWC investigation reports, that personal knowledge was used as a substitute for objective assessment (MWC 2016a; 2014b; 2010c; 2009d).

Discussion based on the case studies and practice experience, highlighted that environment and circumstances in which assessment took place had a significant impact on the outcome, even to the extent of whether an assessment was offered, and if so how 'sympathetically' the person's needs would be viewed. Intoxication, co-morbidity of mental disorders, place of assessment, the attitude, demeanour and physique of the person being assessed were all highlighted. Physical health was also identified as a potentially confounding factor to effective assessment, where for example, an infection may cause temporary cognitive impairment. Participants believed priority was not afforded to recent Government policy which required NHS Boards to ensure that physical health needs of those with severe and enduring mental illness were addressed (Commitment 5, Scottish Executive 2006a). This apparent subjectivity amongst those carrying out assessments for intervention certainly might explain why the framework is applied differently, in apparently similar situations.

Despite emphasis on community care in the Millan Report (Scottish Executive 2001c) short-term compulsory assessment under the 2003 Act (s44) has to at least begin in a hospital setting. Several participants (numbers inflated slightly by Area 2 health trained staff), believed hospital was the best place of assessment for Victor and Drew. This may reflect dominance of the hospital environment for nursing and

medical training (Rogers and Pilgrim 2001) and continuing medical hegemony in the system (Coppock and Dunn 2010).

CPNs in Area 2 cited examples where people behaved in different ways for the consultant depending on their motivation, for example seeking discharge or applying for benefit. This very much echoed Goffman's (1968) ideas around institutional behaviours, suggesting these ideas have continued relevance despite the apparent empowering nature of modern legislation.

The need for detention could be influenced by timing of the assessment according to one group of participants, again a factor not considered by commentators when looking at use of the law. In Victor's case it was suggested he might only try to leave on the day he would usually go out for a drink, so perhaps distraction at this time might obviate the need for detention. Patrick (2008) does differentiate between an 'informed intention' to leave, where detention might be justified and a 'delusion driven' wish to leave which might not justify detention, but does not dwell on circumstantial elements. Whilst participants were aware of the issues around informed intention to leave the suggestion was that most older people on locked wards, or in 'secure care' are not subjected to compulsion, until active, and often aggressive, objections are made to being asked to remain, whatever the rationale.

Research which helped to lay the groundwork for this legislative framework closely examined issues affecting assessment. Stalker, Duckett and Downs (1999) were particularly concerned about the co-existence of learning disability and dementia and saw it as imperative that workers were assisted to engage with, and assess, such

adults more effectively. Participants in this study identified several issues raised in Stalker, Duckett and Downs's research which remained unaddressed, including lack of time for assessments, criticism of one-off assessments, the need for effective communication and paternalistic approaches which denied older people the right to have their view validated. A few MHOs identified taking on a role in translating medical decisions, for the benefit of care management staff, where service users did not fit with eligibility criteria under the law. Policy documents leading to the 2000 and 2003 Acts (Scottish Executive 2001b; SLC 1995) set out rigorous expectations, about transparent assessment processes and interventions, intended to maximise opportunities for participation and provide clear routes for appeal. From these findings it appears that achievements in this regard are limited.

It was suggested earlier, when discussing risk, that people who self-neglect, or self-harm at the lower end of the scale, receive limited support from specialist mental health services. Reflecting on broad approaches to assessment here, those indulging in high-risk behaviours apparently did however, command attention, albeit often very short-term. A few participants, particularly from health backgrounds, expressed the view that people indulged in these behaviours, to generate a response or achieve some benefit. There were however, mixed views around whether such actions were "behavioural" or were symptomatic of underlying problems. Where the behaviour clearly lacked any rationale and lack of perceived culpability, these participants were more comfortable with assessments under the legislation being invoked. A wider group of participants were less comfortable with the fact that, where there was no recognised, treatable mental illness and poor co-operation, such cases would, in practice, be closed very quickly. Several MWC

inquiries highlighted cases where, for similar reasons, services had not engaged with people who presented high risk, resulting in potentially avoidable suicides (MWC 2012e; 2010c).

Whilst the 2007 Act was clearly viewed by many participants as the preserve of local authorities and managers as noted earlier, it was interesting that a few regarded the other two pieces of legislation as essentially medicalised. This seems to directly contradict the policy intent to bring together complex pieces of legislation, focusing on human rights, user involvement and sound multi-agency decision-making (Scottish Government 2009; Scottish Executive 2001c; SLC 1995). Inconsistent approaches to assessment were also identified, in relation to lack of dialogue between police, prosecutors and social work regarding motivation for offending, where mental disorder is present. This was raised in the Area 3 MHO group and echoed in different ways across other groups. Participants across the groups seemed to agree that poor outcomes arose where there was inadequate multi-agency communication whilst undertaking assessment. Discussions in this regard demonstrated the value they attached to important principles on effective integrated working, such as those espoused by the Joint Futures Agenda (Scottish Executive, 2001). Contemporary and subsequent, MWC reports identified failures in assessing risk, connected with poor inter-agency communication (MWC 2012e) or failure to use associated due process such as the CPA (MWC 2009d) suggesting these areas still require attention.

4.7.3.3 Capacity and consent: responsibility and process

Assessing capacity has proved to be a complex and controversial area. The 2000 Act clearly set out the need to focus on decisions that required to be taken rather

than a more binary ‘all or nothing’ type approach (Killeen et al 2004). However, Killeen et al, reinforced this binary approach by introducing models based on global, partial and full capacity, linked to risk and decision-making ‘determinants’ in the 2004 review of the 2000 Act. These ideas were later revised in a guide to assessing capacity incorporated into the code of practice for local authorities (Scottish Government 2008a), the complexities of which were discussed in the review of literature. Participants demonstrated little familiarity with any of this guidance and language such as “did he have capacity” was commonly used in discussions, suggesting this binary approach endures. Having said that language may simply not have caught up with more sophisticated thinking about capacity, which was certainly in evidence at times in group discussions. If on the other hand views on incapacity remain simplistic, it is possible that more subtle nuances will be missed by participants when assessing incapacity.

Strong views were expressed that where incapacity was not obviously linked to mental disorder, social work was left with responsibility for case management without the backing of law. Participants reported difficulty in obtaining capacity assessments from medical staff unless dementia or learning disability was present and care managers reported feeling distanced from decisions around capacity. Faced with lack of support from medical staff, action under the 2000 Act was effectively blocked. These issues seemed for many to go to the heart of difficulties and inconsistencies in using the legislative framework. There were also concerns in several groups about the length of time it took to successfully negotiate capacity assessments. These issues are clearly worthy of closer investigation as they are not addressed in other literature reviewed, including MWC investigation reports.

Many participants identified substance misuse as a barrier both to assessing capacity and diagnosing mental illness, particularly for people with Huntington's disease and older people according to Area 2 care managers. Links between substance misuse and Bipolar Affective Disorder were also identified, alongside concerns about the potentially negative impact drug misuse would have on assessing someone in Drew's position. GPs reportedly refused to undertake assessments, or to take staff concerns seriously in relation to the deteriorating mental state of people, who presented with coexisting substance-related problems. This is disappointing, given that both *"Mind the Gap"* (Scottish Executive, 2003) and *"Closing the Gap"* (Scottish Government, 2007a), urging professionals from all backgrounds to address complex issues around dual-diagnosis, had been in place for several years before the focus groups met. Furthermore, where substance misuse was an issue, there seemed to be little confidence that hospital provided protection from harmful alcohol or drug misuse

The wide-ranging professional perspectives encountered by participants in relation to substance misuse and mental disorder or incapacity, covered three possible areas. These were that substance misuse is the main problem, substance misuse is a symptom of a problem which requires further assessment or it is an obstacle to assessment. In each case these perspectives seemed to legitimise refusing to carry out an assessment under the legislative framework.

An MHO described a woman as "killing herself, abusing herself horribly" (with alcohol) which in his view did not receive a positive response from medical staff who, possibly justifiably, saw no scope for action under the law due to alcohol misuse.

Two MWC inquiries, Mr H (2006b) and Mrs T (2007b) reflect these dynamics. Both were seen to be living in dreadful circumstances, experienced abuse by relatives, and both had alcohol problems, yet received little input from social work, who were criticised for failure to act. The MWC expectations of social work may be seen as unreasonable in such cases. The potential service user may be very uncooperative, relatives input confuses the picture even further and as noted above medical staff often refuse to assess people they perceive to be dependent on alcohol or drugs. The 2003 Act clearly excludes alcohol dependence from the 'meaning of mental disorder' (s328(2)(e)), although many cases discussed suggested that mental disorder was being masked by substance misuse. However, perhaps a wider question needs to be asked as to how society sees its responsibilities to those so badly damaged by alcohol or drug misuse. Prins (1995), Bean (2001) Cox et al (2004) and Greig (2002) all considered ethical aspects of substance misuse, but did not explore in any depth whether or not mental health law could, or indeed should, be involved in the most extreme cases. A small number of participants in this thesis were in no doubt that intervention could be justified in some cases.

Informed consent

Discussion of the Victor case highlighted situations where lack of understanding is the problem rather than incapacity, an issue very much addressed by guidance (Killeen 2008; Killeen et al2004; Scottish Government 2008a, 2008d). Area 1 CMs regarded informed consent as central to the legislative framework and identified the potential for advocates to facilitate understanding. Patrick (2008) contended that advance statements could be treated as a form of advanced consent, but the 2003 Act Code of Practice, clearly advises that advance statements are not binding (Scottish Executive 2005d) and participants themselves rarely mentioned advance

statements in any context. It is clearly possible to make a rational decision to change one's mind in the light of different circumstances, so to use these as some form of advanced consent denies the later opportunity to scrutinise such decisions on behalf of someone who has diminished capacity. Many participants identified power differentials whereby, particularly older people, continue to defer to doctors, evidence that old ways of operating continue to dominate. Despite extensive guidance on taking proper account of people's communication needs when assessing capacity, many participants were concerned that efforts to establish informed consent were brushed aside to allow quicker decision-making.

Expedient assessments

This led to discussion of a more sinister and cynical approach to assessing capacity, and for that matter mental illness, in terms of the 2003 Act. Area 1 MHOs highlighted cases where "expediency" determined whether someone was assessed as lacking capacity or not, directly linked to "bed availability". Even where someone clearly lacked capacity to decide on a move, if their agreement could be gained they were assessed as capable of making the decision. Several Area 2 care managers raised similar points in relation to pressures created by delayed discharge policy, whereby service users were declared as incapable or capable depending on the outcome desired by the medical staff. These may be regarded as deficit models, whereby uninformed or unexpressed compliance is accepted as consent when it suits the professionals. The Killeen et al 'risk orientation' and 'decision-making orientation' models predated debate on deprivation of liberty arising from Bournewood (ECHR 720 2004), however, later guidance also failed to mention these complex dynamics (Killeen 2008; Scottish Government 2008a). Patrick (2008) however, referred to assessing informed or uninformed intentions to leave hospital, in the context of

considering whether consent under 13ZA could be implied. Ward (2007) is however, clear that 13ZA only applies where there is no disagreement and consent is unequivocal. The apparently resource-led approach to assessing capacity described by participants could certainly explain local variation in use of the 2000 Act and 13ZA. It also raised serious ethical concerns and questions over credibility of the framework for participants, as to how far apparent improvements in the law have eradicated pre-existing disrespect for basic human rights.

Given the range of issues arising, it is debatable how capable doctors and for that matter other professionals are, in terms of assessing capacity. Area 1 and 3 participants specifically expressed concern that training is unavailable and about overly simplistic, 'one-off' assessments of capacity, such as the Mini-Mental-State-Examination. The MWC also highlighted simplistic assessment methods which in Mr G's case (MWC 2007c) led many professionals to dismiss dementia as a diagnosis and conclude that he was making informed decisions, and in Mrs T's case (MWC 2007b) conclude that she was capable of agreeing to her violent and abusive son caring for her, both assessments which were subsequently revised. Participants reported that language potentially confuses issues. Terminology across the Acts does seem inconsistent and at times ill-defined: such as the already noted 'risk' and 'significant risk'. The 'significantly impaired decision making' test in the 2003 Act was reportedly used interchangeably with 'incapacity' in the 2000 Act. A few Area 2 participants believed this contributed to differing views on capacity by different psychiatrists.

4.7.3.4 Concluding thoughts on links to the research question

This wide ranging discussion on assessment, consent and diagnosis makes it clear that these areas are still hugely controversial and are often subject to value-based and resource-based judgements, rather than more scientific process. Even where more technical approaches are deployed, these are viewed as simplistic and potentially subject to manipulation. It seems that historic debates about diagnosis, discussed in the review of literature are echoed in modern-day decision making and that the legislative framework, whilst well intentioned and supported by many, is undermined and ignored by many others. Many 'confounding factors' were identified which obstruct effective assessment, whether for diagnostic purposes or in assessing capacity.

Whilst these findings provide some compelling reasons for inconsistent decision-making around the legislation, there is evidence that robust adherence to the criteria and clear understanding of the law might help those exercising social work functions to challenge these inconsistencies, as the priority for those exercising power often seems to favour expedience, rather than the use of evidence as encouraged by legislation. Participants clearly sought further training on assessing capacity and improved processes which are truly multi-disciplinary and multi-agency, issues which could be addressed with additional targeted resources. However, wider value issues and limited resources for specialist care provision are clearly much harder to address. This aspect will be returned to in the conclusions and recommendations.

4.8 Theme Six: Bureaucracy

4.8.2 Introductory comments

Participants were neither prompted nor directed to discuss these issues, the theme simply emerged from the data as in a grounded theory approach (Barbour 2008). As a term, 'bureaucracy' seemed to encompass a range of concerns expressed by participants. These included very strong feelings about increasing demands on teams, shrinking resources and an increasingly anxious management attitude, which it was suggested leads to 'defensive' practice and a blame culture (Titterton 2005). Several issues discussed here have already featured in earlier themes, so where appropriate, links are made back to previous discussions.

The findings relating to this theme provide important evidence in relation to this study. Apparent reasons for regional and local difference in use of the law were evident from focus group discussions. In particular, these differences were believed to arise from management priorities and support structures put in place to satisfy the perceived demands of the legislative framework. Aspects already discussed relating to user involvement, justification for detention and compulsion and assessment of capacity emerged from group discussions and were often examined from a bureaucratic perspective as well as from ethical and practice perspectives. Serious concerns around blame culture arising from conflicting demands were frequently reported and are explored in this section. The findings demonstrate how bureaucratic factors affect the credibility of the framework and interpretation of the law from participants' perspectives.

4.8.3 Findings

The findings are grouped under headings reflecting codes utilised to identify this theme. These include the role of management, autonomy, accountability and resources, sometimes referring directly, or indirectly, to the impact of other bodies on management approaches.

4.8.3.1 The role of management and organisational issues

As noted previously the Area 3 MHO/CM group regarded management as taking a strong lead in terms of the 2007 Act. Participants in the group became quite animated about an early audit of 'vulnerable adult cases' before 2007 Act procedures were even in place. One development officer saw this as a way of getting the processes right, but CM47 pointed out that "one of the problems was it was pre-Act and we were looking at it a year on and many of the recommendations were already in or had been rejected". These audit processes were viewed as an unhelpful preoccupation of management and the wider partnership.

Participants provided clear examples where managerial approaches influenced use of the law. By 2009 when the last of these groups were undertaken none of the three areas had implemented arrangements for local authorities to manage finances under Part 3 of the 2000 Act, and lack of clarity about s13ZA was common, despite both provisions supposedly being enacted in March 2007. MHO17 in Area 2 commented that she did not know when she was supposed to use 13ZA and that such decisions were very "management driven". MHO43, with agreement from the Area 3 MHO group, asserted that "implementation of Part 3 has fallen down a bureaucratic "black hole".

The Area 2 MHO/CM group identified potential for managers to support and enable effective decision-making. An Area 2 MHO/team manager in a different group provided examples of a positive management role in this regard. Area 3 MHOs referred to helpful management guidance for local authority-led applications for financial guardianship. Area 2 CMHT management in adult care, were viewed as quite responsive when risks were identified, quick to call meetings and act where necessary. This was less well supported by Area 2 older people and learning disability services, where staff were still adjusting to uncertainty brought about by new roles arising from newly formed joint community teams.

In contrast CM37, with broad agreement from the Area 2 CM group, presented a different view of local authority managers' role, noting that when pressured from the "powers that be...you are not given the time to investigate it as fully as you would like ... this is a huge decision to make as you are taking away his liberty ... delayed discharge puts added pressure on". Many participants reported being rushed into decisions or forced to use legislation to effect a move, when other possibilities could be considered, highlighted earlier when discussing assessment. An Area 2 MHO group participant (MHO18) similarly identified pressure from their own managers as a factor in decision-making when consultants pushed "to get people out of beds".

Area 1 MHOs were concerned that other disciplines undertaking senior management functions, such as OTs, lacked appropriate social work knowledge and skills to deal with complex decisions. This generated anxiety amongst managers about legislation and their willingness to use the framework and fuelled fears amongst care managers about an increasing blame culture. MHO3 commented that "If I wrote to the manager

of community care to propose guardianship for a compliant adult to go into care he would challenge me". Alternatively, CM14 in Area 1 highlighted a bureaucratic impetus to act, borne out of fear: "sometimes you feel pushed into (running an ASP case conference) to cover your back". She argued that this lack of transparency was poor practice and rather than keep people safe "well if it hits the ... news, we can say we did this and we got everybody together". CM16 strongly agreed, describing case conferencing as "like a 'ticking box thing' then go back to doing what we were going to do anyway".

In Area 1, the MHO group, identified an increase in blame culture linked to the aforementioned SWIA inquiry. MHO5 described a "change in the political climate, with a small 'p', whereby there is a monstrous over-reaction to what are terrible tragedies but result in phenomenal change and reorganisation of resources from one incident". He asserted that change is disproportionate as a result "so you get huge changes over what is perceived to be very negative public reactions".

Outwith social work and health services, improvements since the "early days" were reported in bureaucratic aspects of the MHTS, by Area 1 MHOs: "if you haven't filled in that little circle then application out! Common sense prevails now" (MHO2). Others agreed: "they are not quite so picky now" (MHO6). MHO4 cited power struggles between tribunal members: legal versus medical or non-legal, who she noted are becoming more confident. A few Area 2 MHOs expressed concern at the influence of the Tribunal, highlighting what they perceived as an unhealthy wielding of power, whereby they had, unreasonably, complained about MHOs to management.

4.8.3.2 Autonomy

Autonomy was an issue for many participants, not just MHOs. Care managers technically took the lead in 2000 Act guardianship applications in Area 2, but several felt “disempowered” by lack of knowledge and perceived authority to act when seeking to amend powers in a court setting. Obtaining appropriate advice and authority to express a view was problematic. CM23 regarded the problem as being “driven from above” to agreement from MHO27 who noted that whilst the care manager leads “80% of the time” when the application is lodged legal processes dominate. A NHS employed nurse in the group regard social work as generally very process driven. CM36 saw herself and her CPN role as intrinsically autonomous, but also accountable. CM34, a CLDN did not think her concerns were necessarily valued, but that a social worker raising concern about legislation was more likely to be taken seriously. This was countered by a social worker noting that she was less likely to be taken seriously by health colleagues regarding mental health matters.

To retain a sense of autonomy, CM23 emphasised the need for reliable advice and management support when facing conflict with other professionals, although MHO30 argued that autonomy was rightly limited and that staff should routinely “have to seek and follow advice when using legislation”. In the Area 2 MHO group, a slightly different picture emerged around autonomy. MHO20, with agreement from several others, viewed MHOs as operating independently, asserting that “management do not really understand the role anyway so they just let them get on with it”. Several Area 1 MHOs identified a similar ‘default autonomy’ further noting that non-core team MHOs received no supervision. Despite this MHO18 in Area 2 regarded MHOs independence as compromised, not least, by the “whims of the psychiatrist” in respect of the 2003 Act. In relation to the 2000 Act, others across the groups

commented that solicitors “make up their own minds about what they will put in an application” and sheriffs often disregard the views and recommendations of MHOs in relation to guardianship applications.

4.8.3.3 Accountability

An Area 3 MHO argued that “bureaucratic process” underpins robust systems of accountability. Area 2 MHOs and care managers were in agreement that the law “is also protecting our backs” (CM22 supported by MHO27). An NHS care manager preferred to think of accountability as being to professional bodies and employers and compliance with the requirements of the codes of practice. There was some disagreement amongst CPNs about the benefits or otherwise of reporting issues to line managers, viewed by CM36 as “buck-passing”, but by CM38 .as demonstrating accountability, even if managers chose not to act on expressed concerns.

In Area 1 the MHO group discussion particularly focused on issues of accountability. MHO3 regarded the 2007 Act as having ”made everyone more accountable”. And to unanimous agreement, MHO1 stated that “being more accountable is a good thing but … is a double edged thing too and carries the risk that we become accountable for things over which, in truth, we have no control”. MHO4 agreed noting that “you get to a stage when someone has died ...there was a body in a house in ‘Anytown’ and you breathe a sigh of relief it is not your area”. Another MHO commented that everything is now done much more carefully, “suddenly every word is checked and double checked and this is a new anxiety”. MHO1 with strong agreement from MHO4 added: “new anxiety that is a good phrase”

4.8.3.4 Resources: impact on use of the law

There was considerable focus on resource availability and factors which influence allocation and uptake of resources. Area 3 MHO/CMs noted that “higher management” were unhappy if risk assessments placed extra demands on resources. A few participants welcomed the disappearance of an age cut-off for older people (previously 65), however, inter-professional issues impacted on this and health service managers had very different perspectives, on a range of decision-making, in particular where services for dementia should sit within the structure. Discussion about resources initially focused on the case studies and wider issues arose from these considerations.

CM37, highlighted a need to consider home-based resources in Victor’s case, as an alternative to using the law to move him into care. Use of technology (so-called telecare) to underpin a homecare package was suggested by Area 1 care managers. When considering resources for someone like Harvey, MHO1 argued that spending cut commitments would impact on the “ever-expanding groups to be targeted via these laws”. In fact this group of MHOs doubted if Harvey would even be on social work’s “radar”. Whilst recognising issues of dependence on his parents, lack of resources was an obstacle to intervening “there are no day centre places now in (Anytown), so we would identify that the person does need a day centre but there is nowhere he could go” (MHO4). Others agreed strongly “I think that is a very important point you are making there, because here is a man living with his ageing parents but we can offer very little alternative to someone living in that situation!” (MHO5). Area 3 care managers reflected on the possibility that legislation might help access resources: “having a protection plan in place ... that might actually be a route that might get him into a day centre” (CM47).

The Area 1 MHO group spent some time discussing the impact of the new legislative framework on the available resources in their area, concluding that the “widening of the net created by (the 2007 Act)” (MHO5) added to the increasing drain on MHO resources which were now spread even thinner. Full-time MHOs in this group also reported increasing professional and administrative demands arising from the 2003 Act, one arguing that it “is about 10 times as much work of the old act ... it puts a lot more pressure on all round really” (MHO5). The 2007 Act also reportedly increased workloads “we were becoming increasingly flooded with a sea of bureaucracy” (MHO3). The group could not agree whether in fact there were any new workers to support this Act, and if so, whether the numbers reflect the additional workload.

In a case where a 2007 Act removal order was being considered for a woman aged under 65, Area 2 CM group participants noted that, even if agreement was reached to remove her there was nowhere to take her. As a woman under 65, neither care homes nor hospital were thought suitable and no specialist provision was available.

Reflecting on Drew’s case the Area 3 MHO/CM group cited lack of forensic resources in their local area and thought there should be better cooperation between criminal justice and mental health services. Area 2 MHO/CMs doubted whether there would be sufficient services to meet the high level of need identified by the group to keep someone like Drew at home. Furthermore, it was thought that where someone displayed ‘significant risk’ to others, home support services would be reluctant to get involved.

The Area 3 MHO group seemed more familiar with forensic services and MHO43 commented that there were “bureaucratic obstacles” to using Criminal procedures “it is easier for the police to bring him in for assessment rather than do all that paperwork” (MHO41). MHO41 cited findings of local research on sex offenders in hospital, which demonstrated that informal admission or use of civil procedures following a “flashing episode” was a common response. Seen as a relapse in illness, rather than ‘reoffending’, the potential for heightened levels of risk attached to this behaviour concerned participants, as discussed earlier under the risk theme.

According to MHO lead personnel in Area 1, limited resources led to MHOs undertaking duties, which others could undertake, such as the 2003 Act duty to inquire. Another team manager reported local differences as to how these matters were dealt with, raising the possibility of intra-authority differences, not just inter-authority or interagency. CM7 highlighted a recent occasion where the team leader had refused to invite an MHO to a case conference due to lack of resources.

Following implementation of the 2003 Act, Areas 1 and 2 operated similar models of MHO services, viewed quite positively by participants. Full-time MHO teams were supported by “satellite MHOs” undertaking other duties and based in other teams. Area 3 took a slightly different approach, largely not welcomed by MHO participants. MHOs were physically isolated from social work colleagues, based alongside NHS colleagues and were dependent on the complex array of IT systems, used within integrated services. Problems with these systems were compounded by the social work database, described as “very strange” and likely to allocate anything up to four or five different roles (MHO41), which staff found very confusing. Area 3 MHOs

further commented that they felt devalued in terms of pay and status, noting that since local government ‘‘single status’’ reforms their conditions of employment had worsened.

4.8.4 Discussion

4.8.4.1 Introductory Comments

From a content analysis perspective (Bryman 2008) participants’ frequent reference to ‘bureaucracy’ was notable and additionally many comments clearly linked to disquiet about bureaucratic process. Given the fact, as noted at the outset, that the legislation and codes of practice run to many volumes, this finding is perhaps unsurprising. This discussion focuses on the influence of processes, whether instigated by managers, or consequential to legal changes, on the ability of participants to discharge their functions under the framework. MWC inquiries tend to focus on individual failings, rather than on systemic, organisational and bureaucratic influences on professionals’ actions. The impact of these broader influences on the credibility of the framework for participants was marked and at times the consequences for their interpretation of the framework became apparent. The following discussion sets these findings in the wider context of the current study.

4.8.4.2 Management influences and accountability

Area 1 participants were very concerned about the response of their authority to actual or perceived public censure over failure to utilise adult protection processes. Participants felt that the Government had put the whole framework in place, particularly the 2007 Act, to increase accountability to a degree which was impossible to meet, seeking to achieve outcomes over which services had no control. MWC inquiries often criticise services for failing to act, protect or anticipate need, with the benefit of hindsight and arguably with limited justification. In this

context it is easy to see how these participants' concerns might be validated. Webb (2006) and Reith (1998) referred to risk aversion and the developing emphasis on risk processes and management, which attempt to manage the unmanageable, namely the elimination of risk: or a "new anxiety" as one MHO put it.

In several instances, concern was expressed about managers using legislation to cover their backs, expressed in different ways by many participants and manifesting itself in different approaches. Sometimes this was described as an overly intrusive approach by management, leaving the responsible care manager feeling out of control of her own case. In other cases, workers felt under pressure from their own managers or doctors in NHS, to treat the legislative framework in a pragmatic way to meet organisational, rather than service user needs. For example, where a person was classed as delayed discharge, legislation was avoided to expedite a move to care. On the other hand, where there were high demands on community care services, participants reported being encouraged to use the law to move someone into care, despite the care manager's belief that community options might still be viable. This clearly contradicted the spirit of the 2000 Act as expressed in the original policy document (SLC 1995), which envisaged a transparent, person-centred, human rights compliant framework for decision-making.

Failure of managers, to implement or respect law, was criticised by, mainly MHO, participants across all three authorities. Arrangements for managing finances under Part 3 of the 2000 Act, remained unavailable or at best in the early developmental stage, up to 18 months after the duty has arisen. Another major concern related to pressure to use 13ZA as opposed to guardianship, or in some cases to simply avoid

decision-making around incapacity, by moving people into care without proper authority. Approaches to 13ZA varied widely but none seemed to follow the detailed guidance recommended. There are no statistics about how many local authorities have Part 3 procedures in place or about use of 13ZA, despite a clear commitment to monitor activity when the measure was enacted (Scottish Government 2008a). This perceived disregard for professional accountability, and tendency for personal accountability to be more for the benefit of managers' peace of mind, was frustrating and anxiety-provoking for many participants.

Management decision-making about the legislative framework seemed to focus on areas of risk to the authority, which participants believed engendered a blame culture. Various observers from Beardshaw (1981) to Cole (2011) have reported on this phenomenon. Despite Beardshaw's (1981) account of the consequences for whistleblowing in the NHS, the Government is still promising to rid the organisation of this behaviour over 30 years later, following the mid-Staffordshire inquiry (Francis 2013). A stark characterisation of the fear attached to this apparent blame culture was highlighted, when one participant reported her first reaction, when hearing of the death of a service user was relief that it did not occur in her area.

It is difficult however, to generalise from mixed views amongst the groups about the role of management. There seemed to be different approaches and priorities for different service user groups. Area 2 care management participants were mostly positive about management support and backing for decision-making, whereas the greatest frustration with management was expressed by MHOs and Area 3 participants. Older people services seemed to encounter bureaucratic obstacles and

more arbitrary decision-making related to delayed discharge, provision of residential services and access to complex support packages in the community. This behaviour could reflect discrimination at a structural level as outlined in Thompson's (2012) PCS model whereby society places less value on the needs of older people than others (Lynch 2014), though such conclusions should be treated with caution, given the focus of this thesis and the limited sample.

Structural changes to MHO services resulting from the legislative framework were viewed with concern. Single status arrangements aimed at rebalancing pay grades to reflect responsibilities across Scottish local authorities, reportedly undermined recognition of the MHO role in Areas 2 and 3. Given this occurred at the same time as the 2003 Act which sought to enhance the MHO role, a lack of 'joined up' thinking at government level seems evident. The reorganisation and increasing demands placed upon MHO services by the new legislative framework led to differing models of MHO service delivery (Maas-Lowit 2007). However, even where models are similar, MHO's role differs between local authority areas, for example, in relation to lead roles for guardianship applications as previously discussed. Area 3 MHOs expressed concern that their changed role and relocation to an NHS setting left them feeling marginalised. If such feelings of isolation and disengagement are replicated elsewhere, then MHO services may be less in the forefront of responding to the complex practice agenda about law than is usually suggested (Scottish Executive 2005e). These findings might surprise local authorities who have sought to restructure to ensure their duties are met in the provision of MHO services.

4.8.4.3 Bureaucratic influences on process

Bureaucratic encumbrances to practice arising from the legislation were identified across the three Areas. Several groups debated the relative merits of paperwork and criticised the attitude of other professionals such as police, who according to Area 3 participants, avoided charging people with offences due to paperwork demands. Participants acknowledged the importance of a paper trail in tracking the activities of MDOs, yet deployed powerful metaphors and at times very emotive language indicating very negative feelings about paperwork, describing themselves as “flooded in a sea of bureaucracy”. As noted earlier many participants simply sought advice from people they perceived as experts, rather than engage with lengthy and overly complex guidance materials.

Writers on risk referred to the tendency to raise the value of paperwork above that of professional judgement (Loxton, Shirran and Hothersall 2010; Titterton 2005) and highlighted pressure on social care professionals to become risk technicians (Webb 2006; Castell 1991). Reflecting on the justification for detention and compulsion, commentators questioned whether organisational need for extensive paper trails was prioritised over the need for a sound evidence base (Bean, 2001, Atkinson, 2006). Area 1 MHO expressed concerns about wider bureaucratic demands across the new legislative framework. Whilst tribunals appeared to be less procedural than the old court system, these only deal with the 2003 Act; the Sheriff Courts continue to manage 2000 and 2007 Act applications. Participants’ concerns in relation to bureaucratic legal processes and power differentials in courts and tribunals, suggest more work is needed to achieve aspirations for more inclusive therapeutic jurisprudence processes (Morrow 2012; Wexler 2000).

4.8.4.4 Autonomy and intervention under the legislative framework

National MHO Standards set out clear requirements to provide MHOs with supervision from experienced MHOs and "proper managerial, administrative and technical support" to enable them to fulfil their function (Standard 6, Scottish Executive 2005b). Within this sample group (representing around 3% of practising MHOs) these standards were partially met within full-time MHO teams, but the majority of MHOs in this sample were based outwith full-time teams and received little managerial support or supervision. Even more concerning, across the groups, MHOs reported a form of default autonomy, whereby their managers did not understand their role so allowed them to practice with minimal oversight. Keenan (2012) referred to autonomy of the MHO role, also mentioned by participants, whereby MHOs take independent decisions about detention and compulsion. This is allowed for in the legislation, but lack of managerial oversight is identified as a high risk factor in community care failures (MacKay et al 2011; Reith 1998).

It was interesting that NHS employees perceived themselves to be autonomous and accountable, yet within community teams they have little actual power. Whilst NHS staff have a limited role under the 2000 and 2003 Acts thus far, changes arising from the Public Bodies (Joint Working) (Scotland) Act 2014 may promote further delegation of function.

Autonomy is neither straightforward to define, nor from these findings is it necessarily desirable. Most practitioners across the three areas were clear that their sources of information and support were limited, creating anxiety, stress and inertia. Whilst some valued the autonomy of the MHO role, these seemed to be the more confident and experienced practitioners, located in full-time MHO teams. Even in this

group there was clear frustration about conflicting expectations of management, regulatory bodies and the decision-makers, particularly the Sheriff Court, in relation to Guardianship. Findings demonstrate that MHOs, often the first point of contact for advice, routinely approach other MHOs before responding to queries. This potentially fosters wide variation within and between local areas.

Despite apparent lack of oversight, decision-making power does not sit with either MHOs or care managers, if responses here are representative. Participants highlighted processes which exclude either or both groups, namely managerial interference and perceptions that decision-makers (sheriffs and MHTS) have their own set of priorities. The ability of local authority to act requires co-operation from other professionals, including police, medical staff and local authority lawyers. Therefore, whilst those exercising local authority functions are legally obliged to intervene, a mixture of bureaucratic and relational encumbrances frequently prevent them from so doing. The L and M inquiry (MWC 2006c) identified many similar issues as problematic and further highlighted lack of oversight and expertise in forensic issues amongst involved social workers. The MOP (Scottish Government 2010e) consequently set out clear guidance, if not actual instruction, that local authorities must assign trained and experienced MHOs to restricted patients and supervise them. As noted under the risk theme, training on risk and forensic issues was patchy and from findings under this theme MHOs are poorly supervised and supported.

4.8.4.5 Resources

Many participants reported increases in demands on their time arising from the legislation. Whilst restructuring had taken place in respect of the 2003 Act, many

reported steadily increasing demands arising from the 2000 Act. Despite additional funds allocated to local authorities for implementation of the 2007 Act (Ekosgen 2013), no-one identified additional support at practitioner level, but most reported additional demands on time and reduced resources. Interestingly Area 3 participants cited lack of forensic services despite having a well-established forensic service in the local hospital. This highlights the importance of treating findings based on 'perceptions' with caution. This lack of awareness may be a consequence of the historic tendency to keep mental health services separate from the wider community (Shorter 1997; Scull 1996).

Several participants referred to using the legislation to mobilise services, despite principles in the 2003 and 2007 Acts which set out a clear expectation that people should be provided with services on an equitable basis regardless of their legal status. Many participants did not believe someone in Harvey's situation would be seen as a priority, albeit several participants thought the 2007 Act was broadening the group of people who might be subject to legislation. Participants further suggested that where day centre places or locations utilised for assessment or "place of safety" under the 2003 or 2007 Acts were unavailable, use of legislation would be avoided to mask lack of resources.

Knowles (2000) asserted that unless money followed patients from hospital to the community, communities would be unable to support the mentally ill and efforts to support the mentally ill or provide community care would fail. Arguably failure to recognise Harvey as being in need reflects Scull's view (1996) that dependency is

discouraged and somehow seen as immoral, resulting in cutbacks to essential services for those with long-term mental disorder.

In conclusion it appears that the legislative framework may be used inappropriately to prioritise access to services or to place people in institutional care where resources are unavailable, or conversely, compulsory measures may be avoided, in case this highlights lack of resources to meet identified needs. Given the limitations around number and representativeness of the sample, this can only be an 'indicative' finding; however, these issues would merit further research and consideration by those planning new or expanded services.

4.8.4.6 Concluding thought on links to the research question

A range of 'bureaucratic' issues, in the widest sense of the term, clearly impact on use of the law. This section examined managerial processes and external factors which at times intimidate or impinge on the ability of staff to act, yet at other times support staff in difficult situations. Fear of getting things wrong was linked to discomfort with bureaucratic processes and ideas around 'blame culture'.

Lack of knowledge amongst managers about MHO functions led to more localised policy around use of legislation and at times managers' interventions prevented appropriate use of legislation, either due to limited resources or fear of criticism. MHOs exercised autonomy by default, because managers lacked knowledge of the legislation and did not perceive a need to take control. All these factors potentially lead to local differences in implementation of the law. Many participants asserted that availability of resources had a significant impact on their ability to intervene, implying a resource-led approach, rather than a more ethical, needs-led approach

and far from the more inclusive person-centred approaches encouraged by the legal framework. Resource availability might, therefore, also have an impact on local variation in use of the Acts.

The focus groups met shortly after the 2008 economic crash, but it seems likely that lack of resources remains a problem in the light of the Spending Review (HM Treasury 2010) and increasing policy and legislative demands on local authorities, for example Self Directed Support (Scotland) Act 2013 and Keys for Life (Scottish Government 2013b). Another reported impediment to use of the legal framework related to the interaction with other professionals and their tendency to avoid their own agencies bureaucratic processes.

Finally, given the voluminous statute how far staff understand their duties remains open to question. A few staff acknowledged they did not read guidance documents, but there was evidence that most staff involved in the frontline of delivering on the legislative framework had a reasonable understanding of their duties and powers under the Acts, as evidenced under this theme and others. These findings do not show the same for managers, who seemed to take decisions in the absence of knowledge of the framework, an issue which would benefit from further investigation.

Overall it seems that many participants believed that the legislative framework, at least in part, was used to protect managers and organisations, rather than individuals subject to it. Evidence of discrimination towards older people was highlighted in that the priorities seemed more focused on managing delayed discharge and expedient decisions about placing people in care. Overall this

undermined the credibility of the law for several and influenced how the law was interpreted. It seemed that participants more often used the law to underpin defensible or at times defensive practice (Titterton 2005), rather than in a more pro-active way to achieve the best outcomes and respect the rights of those subject to it.

4.9 Theme Seven: Human rights aspects

4.9.1 Introductory thoughts

This theme reflects a broad range of issues relating to respect for human rights. Many participants expressed concern about unreasonable and unauthorised deprivation of liberty, specifically related to use of restraint, accommodation and managing complexities over the right of people to make informed choices about lifestyle.

Discussion about criminal procedures generated several codes related to human rights, whether for the perpetrator or the victim, so MDO work is included as a sub-heading under this theme. Discussion about stigma was fairly muted amongst participants though some issues raised by participants, for example discriminatory behaviour toward people with mental illness were underpinned by stigma (Thompson 2012), even if that word was not used to describe it. This issue seemed to fit best with consideration of human rights.

Given the importance participants seemed to attach to respect for human rights, perceptions of how far the legislative framework promotes respect for human rights

is a measure of the credibility of the framework from their perspective. This theme also reflects perceptions of the evidence base for the legislative framework and the transparency and fairness of associated decision-making processes. This thesis cannot cover the range of complexities associated with human rights in detail, but many areas identified in the 'Discussion' section on this theme would certainly merit further research.

4.9.2 Findings

To provide some structure these findings are divided into four sections: deprivation of liberty and the law; deprivation of liberty and lifestyle; criminal proceedings and stigma.

4.9.2.1 Deprivation of liberty and use of the law to underpin interventions

There was considerable debate across the groups about protecting the human rights of people who were prevented from leaving hospital. MHO46 in Area 3 regarded use of s47 of the 2000 Act to keep older people on locked wards positively "I think it is about providing care in a secure environment", but most others disagreed. Whilst a few accepted that providing care might be authorised by s47, most were clear using restraint to prevent someone leaving could not. Discussion in the Area 2 mixed group produced differing views over whether someone like Victor would be "deprived of his liberty" whilst in hospital. Three participants believed his rights were being compromised while two were not convinced. One participant provided a case example, where a woman was effectively held in hospital with no legislative authority for 6 months awaiting a care placement, because the family had not yet applied for guardianship. MHO27 compared this situation with Victor's: "so this guy is stuck, basically there is no framework to protect him or at least to challenge the decisions that are being made". Area 3 MHOs thought it unlikely the 2003 Act would be used to

keep Victor in hospital, though one noted it may be justified as Victor clearly stated he did not want to be there. MHOs also suggested Victor might find himself admitted to a care home under false pretences, by means of the earlier noted "scooping up" approach. MHO46 asserted that very few older people were detained in hospital in Area 3. This group demonstrated keen awareness of deprivation of liberty issues and 13ZA and expressed concern around the lack of legal protection afforded by this measure, adding that despite this, 13ZA would now routinely authorise nursing home placements, where previously 2000 Act measures would have been used.

There was also debate in the Area 1 mixed group about 13ZA. CM12 asked if they would use 13ZA to move Victor in response to a question about the 2000 Act. CM7 did not know what it was and CM11 contributed "this is the legally dodgy one isn't it?" An MHO team manager explained the provision concisely and accurately to the group. Others were aware of debate around 13ZA in their area, though CM12 stated that they had always used informal approaches. Several participants acknowledged that such informal approaches could be legally challenged, but that in practice people would struggle to exercise those rights. MHO10 outlined what he saw as a contradictory position taken by the Government about deprivation of liberty and 13ZA: "the Scottish Government has a convoluted argument that being looked after in hospital is more restrictive than … in a care home so therefore you are not depriving someone of their liberty by moving them from hospital to a care home"

Most participants agreed that someone in Victor's position would not be detained unless he was actively trying to leave, but given that he wished to go home, an Area 1 MHO argued that hospital authorities should justify why they would **not** use legal

measures to detain him. Several Area 2 MHOs suggested a decision to detain Victor would depend on identified risks and his willingness to remain in hospital. To general agreement, MHO19 noted that if the level of risk associated with going home was high, the 2003 Act might be used to keep him there, whereas if his welfare was at risk, the 2000 Act might be used to place him in care or underpin community services. A newly qualified MHO questioned whether welfare guardianship could be used to return someone to a general hospital, about which there was some disagreement.

Use of the 2000 Act to underpin community care arrangements was regarded with scepticism across the groups. MHO4's comments reflected the views of many participants on this topic: "where somebody refuses to stay in a place under a guardianship order you are limited as to what you can do … the only way you can get them to stay in one place is to put them on a locked ward. That is the sad truth really"

When reflecting on care at home, discussion about covert medication and the 2000 Act, revealed an interesting point about human rights. MHO1 suggested that courts would take a more sympathetic view of parents giving covert medications for adult children, as opposed to care homes doing the same thing, suggesting that a person's human rights were less likely to be respected when living in their own home.

4.9.2.2 Lifestyle choice and deprivation of liberty

Discussion about lifestyle choice has arisen under several themes, but here the emphasis is on ethical aspects. Area 1 MHOs were particularly concerned about the

poorly defined criteria for investigations under s4 of the 2007 Act, which presents challenges in weighing up accountability for services when deciding whether to support adults to take risks or intervene to prevent them from taking risks. MHO3 welcomed this new accountability as it might protect those not previously protected by law. However, he expressed concern that people who were “mildly impaired” might get “sucked into” investigations simply because their lifestyle was viewed as worrying: “it is quite difficult to consider where someone should come along and say actually no we are seriously concerned about this and we are going to do ‘x’ rather than allow the person to make a choice to continue with the behaviour they are engaging in”

Area 2 MHOs reflected on costs and benefits for Harvey when attempting to strike a balance between allowing him choose to have friendships and potentially exposing him to exploitation. This reflected a common thread of discussion across many groups and it was suggested that this balance was not explored in enough depth in many cases. Area 2 CMs discussed a case where a mental health assessment had proved inconclusive, so a 2000 Act case conference was called to consider guardianship and decide whether the concerning behaviour was the product of incapacity or was a lifestyle choice. Despite some agreement between the services about the nature of risks, there was none on whether the criteria for the 2000 Act were met. This was important from an ethical standpoint, particularly as alcohol misuse was a factor. Interestingly the clash of views here was between mental health services, who regarded alcohol misuse as a lifestyle choice and criminal justice services, who linked this behaviour to incapacity.

Others in the Area 2 CM group provided examples of dilemmas between lifestyle and the need to intervene. CM36 (a CPN) stated that they get many phonecalls “saying that we have been to visit so and so and the state of the flat is abysmal and they must be either incapacitated or mentally ill to live like that and they are not – it is a lifestyle choice”. CM32 agreed and provided another example where multiple concerns had been expressed about the treatment of a man who was now “quite poorly” and was seen as a “vulnerable adult”, by his wife. She described a long standing volatile relationship between the couple and noted that: “he is kind of like a hen-pecked husband, the people who go in to assist him feel that the way she speaks to him isn’t ... right and I almost find myself justifying their relationship and I don’t feel we should be getting involved ... and from time to time I have had to call upon doctors and things ... just to appease the workers”. She pointed out that people who only see the adult for a few minutes at a time are making “big judgements”, and then leaving it for the care manager to take responsibility.

The Area 1 MHO group debated similar issues around the milder end of incapacity, citing examples where professionals try to impose change, because of their own discomfort about lifestyle choices people are making, again citing alcohol misuse. MHO3 noted that “alcohol dependency is a good example of people that have not really been offered a service by our department at first”. This provoked some debate in the group about relationships between substance misuse, lifestyle and vulnerability. MHO5 stated “people with drug addictions are considered vulnerable adults where people with alcohol problems are not”. Although not endorsed by all, it was agreed that the 2007 Act had led to many more referrals and that whilst substance misuse cannot in itself be a reason to intervene, associated issues of

vulnerability and risk often did merit intervention: “we’re offering quite a lot of services to adults who are vulnerable that we haven’t engaged with for years” (MHO6). Association between alcohol or drug misuse and “qualifying factors under law” commonly posed dilemmas in learning disability and mental health cases. MHO4, with agreement from several participants, asserted that alcohol made “people more vulnerable to abuse from other people”. MHO1 further commented: “we are seeing one sort of condition as an illness while other sorts of conditions, alcoholism amongst them, are not straightforwardly an illness though have many of the features of an illness, we are saying there is a vital distinction”, alluding not just to diagnosis, but to legislative criteria, an issue already discussed under the diagnosis theme.

4.9.2.3. Criminal proceedings

There was in-depth discussion about the Drew case study across the groups, leading on to some wider discussion about different options and related case examples. The first section looks at the range of responses discussed by participants.

Statutory responses

In the Area 2 MHO/CM group many participants argued that responses to Drew should be “assertive”, emphasising treatment rather than punishment. Area 3 MHOs, reached similar conclusions and argued that a compulsion order (CPSA) would respect his “right to treatment” and would be properly reviewed. Participants in other areas expressed clear preference for a CPSA response, rather than a prison sentence, partly to hold him “accountable” (CM21), but also viewed this route as “protective, for perpetrators with mental disorder” (MHO25). Despite expressing concerns about prosecutors failing to use criminal processes for the mentally

disordered, no participants suggested straightforward criminal justice responses for Drew, citing potential for ill-treatment or suicide in prison. Several participants noted that even if he was stable, treatment, not prison, should be the preferred option where major mental illness was involved, as coping with prison may cause relapse: “he would land up being one of these people who are inappropriately imprisoned and need to be rescued” (MHO27).

MHOs in Area 3 preferred an Assessment Order under the CPSA, though MHO43, acknowledging she did not fully understand CPSA processes, preferred a civil order on the grounds this behaviour only occurs when he is “high”: “I wouldn’t like at this stage to say he is bad I would prefer to say he is mad”. Other MHOs in the group disagreed, arguing that an Assessment Order would give time to establish his mental state, creating an “important paper trail to track risk” (MHO41), but not necessarily label him as an offender.

In the Area 1 MHO/CM group, one MHO team leader believed the civil STDC route offered an urgent response to Drew’s behaviour. Area 1 MHOs agreed this route was the right initial response. Others preferred the CPSA route, though MHO10 (a criminal justice team leader) described the ideal route as probation with a treatment condition. She believed the case would be dropped, especially if a STDC was already in place. MHO1 agreed “it is something of a lottery ... if it gets past fiscal or not ... I think sometimes staff regret that; they would more often like to see people run through the full process”. Area 3 MHOs reached similar conclusions about criminal prosecutions.

MHO3 cited a local case of a man with schizophrenia, who threatened a taxi driver with a knife, because he thought he was plotting against him. He received a three-year jail sentence, yet “when he is well he is one of the nicest guys you could hope to meet and even three years later he is still devastated he was subject to criminal procedures”. MHO5 thought if charges involved a knife, the focus of risk management and assessment would be on risk to others: maybe utilising parallel processes of criminal justice and civil treatment. MHO1 strongly endorsed by MHO3, stated that possessing or using a knife “in the present climate ... government policy, police initiatives, high profile murders and all that, that just crosses a line”

CM7 recalled a psychiatrist’s view in a recent case discussion where the perpetrator had personality disorder and illicit drugs were involved: “it is situational … nothing to do with psychiatry - we are not taking them in”. CM12 noted if a straightforward criminal justice route was chosen for Drew, a fine, or a short prison sentence was the most likely outcome, but all agreed this would be over quite quickly. When asked about the duration of involvement if a CPSA route was followed, various responses, reflecting a degree of dark humour, were offered: “35 years”; “as long as it takes to make him a reasonable human being”; “get a restriction thrown in we could keep him for life”. Despite apparent concern about the open-ended nature of CPSA responses, the group did not view the shorter criminal justice route as helpful; rather the civil (or CPSA) routes would look after his best interests. Allowing him freedom too soon could result in him killing someone: “not doing him any favours – nor indeed the person who is his victim” (MHO10).

Area 1 MHOs and Area 3 MHO/CM groups also reflected on timescales when debating use of criminal procedures for Drew. MHO2 noted someone committing murder and subject to mental health processes could be incarcerated for three or more decades, whereas ordinary criminal procedures might allow him out in twelve years. CM48 suggested “he could be kept in hospital much longer than would be fair” later acknowledging that this seemed like a new perspective “almost the opposite of the perception that people are never put in prison for long enough for violent offences”. MHO1 defended mental health disposals, arguing that these are reviewed, though MHO5 contended that the parole system was much more transparent than the mental health system, where “it is harder to get out because the decision-making is not always so clear”. A discussion in the Area 1 mixed group came to similar conclusions suggesting that Drew might get a “raw deal” in the mental health system. CM14 cited a learning disability case where a person was removed from prison on a Transfer for Treatment Directive (CPSA) which she believed was quite “draconian”, albeit acknowledging it protected his rights. MHO40 believed that forensic psychiatric services are much more effective at dealing with offending behaviours. MHO42 agreed, adding that NHS learning disability services were much clearer than social work, about the efficacy of criminal procedures for dealing with challenging behaviours, in people with learning disability.

Most of the Area 3 MHO/CM group, favoured Drew’s incarceration in hospital, through a civil or CPSA route. Area 2 MHOs believed Drew should be “locked up”, again like the Area 1 MHO/CM group, resorting to slightly dark humour to express this. However, they urged caution and favoured civil processes, highlighting the danger of overestimating his capacity to understand the procedures, and

consequences of his behaviour. MHO17 noted that “maybe he is threatening because he feels fearful or maybe it is the way he looks you know he is a kind of threatening person anyway”. There was consensus not to rush to simple criminal procedures, due to concern about the potential impact of a prison sentence on Drew, but to look at hospital admission to allow mental state assessments.

Assessing culpability

Culpability proved to be an area of great interest to a few participants. CM47 in the Area 3 MHO/CM group introduced the topic “you need to assess what part his illness has played”. MHO41 stated: ”an awful lot of guys” are just playing the game “I wasn’t well”, he paraphrased, but in his view they knew exactly what they were doing. He described a young man with learning disability as the “best shoplifter I ever knew”, claiming he would steal to order but was never charged because he put on “the whole persona ... I don’t know what I am doing, I didn’t even know I was in the shop and he would get a pat on the head and sent out”.

CM36 an Area 2 CPNs expressed the view that “they are choosing to do this they can also choose to stop it, it is under their control”, concluding that only if a person was mentally ill and unable to control their behaviour do “we” have a duty to intervene. He suggested Drew’s assertions about “immunity” to prosecution, might lead to escalation and reinforce an inflated view of self. He further suggested this idea of immunity implies Drew has insight into his behaviour. A social worker, CM37, referred to a man with a physical disability she worked with, who set fire to his flat, who was seen as culpable and sentenced under criminal law. Before the trial he claimed he would get “off scot free ‘cos he was going to go down the mental health route”.

Under-reaction by prosecutors and psychiatrists to high risk issues

Doubts around culpability seemed to lead to more informal responses, a matter of considerable concern for many participants. MHO40 cited a case of a man stalking a woman who was picked up numerous times by police and taken home, but eventually when they entered his house they found "equipment" including a telescope, and it became clear that he presented a huge risk. Prior to this his claims that he was not well had been believed. MHO3 cited a similarly concerning case where a man presented much like Drew, but with psychotic symptoms. He "was obsessed about his dentist and said that his dentist was affecting his behaviour, was behaving in that manner and there wasn't much done about that and he in fact stabbed his dentist".

Area 1 MHO/CM group identified yet another similar case where a man with Asperger's targeted young girls including his neighbour's daughter, expressing a desire for sexual relationships. Apprehended by police he apparently claimed "I won't get charged because I've got Asperger's" (CM12). He was already on their risk management database, but despite case conferences, acknowledgement he was stalking his neighbour's young daughter, even after direct contact by the lead police officer with the procurator fiscal, the case was dismissed.

In Area 2, CM38 described a case where a mentally ill man, who beat his wife attended court for sentencing. The RMO reportedly said "it is just farcical that he has to go through all these procedures … he has a mental illness he shouldn't have to go through it". CM31 referred to a man, who could neither read nor write, who was "constantly" going to bridges and threatening to jump, or phoning 999. Police saw

him as harmless and never charged him. However, CM31 and his son both wanted him charged as they believed he learned by example. Eventually he appeared before a Sheriff who “saw him as a little old man, so again nothing happened and again you are back where you started”.

MHO17 described one case where CID were apparently contacted following an incident in a learning disability unit and it took five months for police to visit the perpetrator: “we find the police visit people in units (after the report of an assault) and see - it is people with learning disabilities and don’t want to get involved – see it as a bit of a scrap”. However, she acknowledged some recent improvement in police responses.

4.9.2.4 Stigma

The Area 3 MHO/CM group suggested that Harvey would experience stigma and that raising empowerment with his parents might help them understand the importance of supporting his independence, if necessary by means of legal intervention. A few participants raised the issue of stigma and discrimination in respect of hospital staff and attitudes towards Victor, which could undermine attempts at rehabilitation.

MHO30 was the only participant calling for diversion from prosecution for Drew, citing concerns that criminal procedures would lead to stigma. Others cited the Jonathan Zito, Steven Hoskins cases and the priority on arrests for possession of knives in the general population, as grounds for more punitive measures.

Alternately, the Area 3 MHO group identified “reverse discrimination” and stigma, whereby not using formal processes was potentially discriminatory as it denied people like Drew much needed treatment. Area 2 MHOs were the only group to highlight, the impact of stigma on someone who was never previously detained.

4.9.3 Discussion

As noted at the beginning of this section, deprivation of liberty, aspects of criminal justice and stigma were key elements to considering human rights compliance in implementing the legislative framework. Other aspects of human rights have already been considered under other themes, for example, rights to involvement and consultation in care planning and fair processes which allow people to go about their day-to-day business and, at times, take risks.

4.9.3.1 Deprivation of liberty

Introductory comments

The effective management of deprivation of liberty has become a litmus test for the relevance and efficacy of the legislative framework for many commentators (MWC 2013b, 2006d; SLC 2012; Patrick 2009, 2008; Atkinson et al 2007, 2005; Scottish Executive 2001). Article 5(1)(f) of the ECHR makes clear that “everyone has the right to liberty and security of person” and that this shall not be interfered with except by a proper legal process and in this context only where the person is of unsound mind. Those subject to restriction should have rights of appeal, representation and involvement in processes and any response should be proportionate, reasonable and the least restrictive possible. The principles of all the Acts, according to the above writers not least, underpin compliance with legal requirements to respect human rights. Criticisms about use of the 2000 Act and efforts to be compliant with

findings of the Bournewood Judgement (ECHR 720 2004), resulted in the creation of s13ZA. However, cases cited in the literature review and earlier discussion under the ‘use of legislation’ theme increasingly calls into question how far 13ZA complies with ECHR requirements regarding deprivation of liberty.

Participants identified issues about deprivation of liberty in hospitals, care homes and in the community, so this section is split into two parts, firstly examining the implications for in-patients and secondly for those living in community settings, whether their own homes or care establishments.

In-patient settings

Participants across the groups were very conscious of issues around deprivation of liberty and the contradictions identified by those interpreting the legislative framework. Many participants were aware of the Bournewood judgement (ECHR 720 2004) and were, either critical of the way the recommendations were addressed, or expressed concern about people’s ability to consent to receiving hospital or community care services. Although the Victor case study implicitly invited consideration of such issues, these were neither explicitly stated, nor directly prompted by the associated questions; therefore these responses may be viewed as reflecting participants own perspectives on current practice issues.

The circumstances in which people were kept in hospital prompted a significant amount of debate. What was clear from responses across most groups was that the vast majority of older people on psychiatric wards, regardless of their capacity to agree to be there, were not detained. Use of s47 of the 2000 Act to underpin hospital stays, reported by several participants in Areas 1 and 3, would not satisfy the Article

5(1)(f) requirements. S47 allows medical treatment to be administered, subject to relevant certificates being signed, but use of force or detention is only permitted in very limited circumstances. Most participants believed other compulsory measures would only be used where active attempts were being made to leave or where significant restraint was required.

Updated MWC guidance asserts that where someone is physically incapable of reaching a door to leave, but is clearly, and regularly, seeking to do so, this should be considered restraint requiring legal authorisation. Even regular verbal distraction from the person's intention to leave, may be considered 'restraint' (MWC 2013b). The guidance advises 'common law' may be used to justify isolated incidents of restraint, but that the 2000 or 2003 Act must be considered when this is regularly required. No reference is made to Patrick (2008), a paper commissioned by the MWC, which argues that the 2000 Act cannot authorise any form of detention or restraint, nor does this guidance acknowledge that few older people in hospital or care homes are subject to either Act. The guidance also fails to even mention 13ZA, a topic which very much exercised the minds of participants. It therefore seems that in some respects the MWC speak with the authority of a regulator on this important issue, the guidance avoids issues which reflect the views or concerns of practitioners as expressed in this study.

Area 3 participants seemed to be clear that 13ZA was the usual route, in their area, to move a person who lacks capacity to agree, into a care home, though many expressed concerns around lack of legal protection and appeal processes, anticipating the later concerns about 13ZA noted above. In Area 1 not all participants

were aware of 13ZA, though one who did have some knowledge, referred to this as the “dodgy one”.

An experienced care manager noted that informal approaches had been used in Area 1, prior to 13ZA. This echoed discussion in Areas 2 and 3 where it was clear such approaches continue to be used. This involved admitting people to care homes by means of deception, on the basis that they would soon forget how they got there anyway, which a few participants, viewed as potentially less distressing than formalised processes. Such an approach would certainly be least restrictive and potentially beneficial to the ‘adult’, once due legal process has been completed and the service user’s rights have been respected and protected, as intended by legislation. However, from a human rights perspective, without the due process, this approach subverts the intentions of legislation and the ECHR (SLC, 1995; Scottish Executive 2001c).

Community

Wide concerns were evident around a range of issues relating to community living some regarded as lifestyle choice, impacting on the authority or motivation of professionals to intervene. These are divided into sub-headings to focus this part of the discussion.

Mental disorder and substance misuse (dual-diagnosis)

Participants repeatedly referred to the impact of substance use on people’s lifestyles, regarded across all three areas as a barrier to intervention. However, in Area 1 a team leader argued that the 2007 Act had widened the net, bringing this new group of people into contact with social work for the first time on the basis of “lifestyle” issues. This was welcomed by many participants as few disagreed that alcohol

increases susceptibility to abuse and that many people with co-existing mental health difficulties, would not previously have received a service. These are interesting findings as 2007 Act interventions are essentially founded on the definition of mental disorder in s328 of the 2003 Act, which specifically excludes dependency on alcohol or drugs. The Millan report (Scottish Executive 2001c), acknowledges the complexity of substance misuse problems, but suggests that the essential difference is that substance misuse is entered into on a voluntary basis. Several MWC inquiries have urged authorities to look at the links between mental disorder and substance misuse more closely (MWC 2012f; MWC 2012e; MWC 2006b).

Many participants reported severe difficulties in mobilising support from primary care and psychiatric services, for people where substance misuse was a prominent feature. Legislators seemed to view problems between substance misuse and mental health services as more organisational, rather than a failing of law (Scottish Executive 2001c), but in practice situations, according to participants, community services struggle to manage the complexities of co-existing conditions. This echoes evidence from stakeholders cited in many policy documents (Scottish Government 2007c; Scottish Executive 2006a; Scottish Executive 2003) all of which seek to ensure those with dual-diagnosis receive appropriate support. Evidence from participants suggests that problems addressing dual-diagnosis and access to services are even further exacerbated by complexities associated with impaired capacity related to physical disability, discussed elsewhere in this thesis.

Covert medication

Covert medication, already discussed elsewhere in this document, presents additional challenges in respecting human rights in community living situations. A few participants identified double standards whereby informal carers can administer covert medication, use coercive practices or carry out moving and handling manoeuvres breaching health and safety regulations, in a way that care professionals could not, thereby impinging on the human rights of service users. It was unclear how far this was challenged or tolerated by care managers. Under SDS 2013 a welfare guardian (the 2000 Act) can now manage direct payments, extending the scope for family members to act as personal assistants, but potentially increasing the concentration of power in fewer hands. This interface between the two Acts risks compromising human rights and should be considered as part of SDS 2013 monitoring processes.

Older people

Despite clear direction to ensure equal treatment (2003 and 2007 Act principles), participants reported differing treatment of older people, compared to others, when assessing and managing risk and improper use of legislation in relation to care admissions. The Mrs I report (MWC 2010b) suggested that services may have resisted intervening in her affairs because of her age and that a younger person would not have been allowed to slip into such a state of neglect. These findings accord with more general concerns about discrimination against older people highlighted in reports such as *Better health, Better care* (Scottish Government 2007b) and *'All our futures'* (Scottish Government, 2007a). The latter document noted that "Although far more common, age-related disability is often regarded differently from disability acquired at birth or earlier in life", by which they mean less

favourably (Scottish Government 2007a p11). Underpinning these problems about service delivery are failures to adequately diagnose, assess and treat older people in the wider context of physical disability, mental disorder and incapacity, discussed elsewhere in this thesis. If, as seems probable, provision of services is now more closely linked to risk than need (Loxton, Shirran and Hothersall 2010; Titterton 2005), then failure to properly risk assess older people may leave them without adequate services, despite the intentions of legislation.

The 2007 Act

A further point from a human rights perspective, in relation to community living and lifestyle, arose from discussion about the fact that the 2007 Act is principally used for investigation and inquiry (Ekosgen 2013). Investigative powers under s4 are very briefly stated and the related Code of Practice (Scottish Government 2008b) provides little guidance, so local policy largely dictates procedures for case conferencing and investigation. For many participants significant ethical problems arose in such investigations, when the legal basis was weak, consent was in doubt or people were living 'eccentric' lifestyles. An example was provided where frequent, at times unhelpful, reports on a couples' behaviour, pathologised as abusive by care providers, was in fact normal for that couple and not regarded as harmful by those who knew them better.

Despite these problems, participants were clear that 2007 Act investigative processes, broadly modelled on child protection procedures, allow them unprecedented access to adults who may be at risk and provide opportunities to enter into dialogue with other professionals, regarding the living situations of adults with disabilities. Supporters of the 2007 Act argue that it provides a forum for

complex issues to be debated and resolved and the principles of the three Acts provide an objective basis for professionals to reach resolution (Keenan 2012), but wide differences of opinion amongst participants were evident in this regard.

Use of locked environment in community settings

Participants' were very animated regarding restrictions on community living. Legislative powers are difficult to invoke, where people are resistant and continue to live in the community, as evidenced in literature, not least by Patrick (2008). Most participants in this study agreed that guardianship could not effectively authorise restrictions in peoples' own homes and that the only practical way of limiting people's behaviour was detention in hospital. This could equally apply in more open care home settings, whereby the restriction necessary to protect people from exploitation or misadventure goes beyond what is practical. Guardianship is commonly used to effectively 'detain' people, commonly those with learning disability, in their own tenancies or in small-group care homes.

Whilst Patrick (2008) agrees that guardianship may be insufficient authority to underpin such arrangements, her suggested solution of using the 2003 Act, as discussed in the review of literature (2.11.2), was not familiar to participants. It is in any case likely that use of the 2003 Act would be resisted by gatekeepers, particularly psychiatry or general medical wards, who have no wish to widen the group liable to hospital detention (Richardson 2007; Rogers and Pilgrim 2001). Interestingly and contrary to these perspectives the Justice Denied report (MWC, 2008b) argues that guardianship could authorise deprivation of liberty as part of a restrictive community-based care package. However, if Ms A's compliance lapsed, there would be little alternative to placing her in a locked environment, to keep her

safe from sexual exploitation. Paradoxically it seems that legal measures intended to facilitate community living can only be enforced by very restrictive means, utilising very high staffing ratios or admitting people to secure environments. Using the 2000 Act to support incarceration rather than taking managed risks in the community, seems to place greater emphasis on 'defensive' approaches to community living, than more 'defensible' approaches based on positive risk-taking (Titterton 2005). Furthermore, perhaps this indicates that in Scotland as in the USA and Canada, failure to transfer sufficient resources from hospital to community results in increased use of compulsion (Knowles 2000).

Overview of issues using legislation to underpin deprivation of liberty

Several human rights dilemmas arise relating to deprivation of liberty: how far is it reasonable for authorities to intervene to moderate or change lifestyle, what is the legislative basis for this and how can agreement be reached on these issues? Participants' perspectives on these issues are enlightening. Without support of medical staff, MHTS, sheriffs or in some cases prosecutors, intervention cannot take place. Whilst these gatekeepers can be viewed as a check on the system, several participants, backed by commentary in MWC inquiries, highlighted several issues. These included failures to communicate or use proper processes, value differences resulting in failure to intervene in a timely manner and limited agreement as to how to resolve such dilemmas. Participants were uncomfortable with outcomes which restrict liberty and choice and reported particular concern over failure of gatekeepers to engage with older people and those with substance misuse problems, often due to discriminatory attitudes. It appears that addressing deprivation of liberty remains a major challenge for implementing this legislative framework.

4.9.3.2 Criminal procedures

Interventions relating to criminal procedures bring into sharp focus, issues of discrimination, stigma and risk management, all of which arguably influence the public attitude to mental disorder and incapacity more generally. This area is a rich source for future research and can only be touched upon here, but given that 2003 Act reforms sought to address issues around mental disorder and criminal justice processes, it is relevant to this research. As noted in the introduction to this theme, deliberation on these matters is closely tied in with human rights considerations.

Two key aspects might have been expected to arise in discussions around these issues: firstly, how perpetrators with mental disorder, including incapacity, were treated in the criminal justice system and secondly how victims of crime, including those with mental disorder, are treated in the same system. Perhaps because there was less disagreement within the participant groups, there was very limited discussion relating to victims of crime. It is acknowledged this may relate to how the Drew case study, focused on him as a perpetrator of crime. The legislative framework itself makes little reference to victims of crime as this is dealt with by other legislative means. Failings in the system for victims of crime including those with mental disorder are very much acknowledged in the review of literature, for example with reference to the Justice Denied report (MWC 2008a), the introduction of the Vulnerable Witnesses Act (Scotland) 2004 and reforms to the Appropriate Adult Scheme (Thomson, Galt and Darjee 2004). However, the main focus for participants was the legal response to MDOs. With reference to the ‘Drew’ case study the vast majority of participants, particularly MHO groups, viewed the CPSA route to placing him in hospital as the best option. A few argued for a purely ‘civil’ disposal such as STDC or guardianship (seen as a most unusual response), and no-

one openly argued for straightforward criminal justice responses. Following discussions relating to Drew, many participants were quick to bring in real case examples and express their personal views and those of their organisations.

The headings used below to help structure the discussion relate to these three ‘disposals’ or routes to responding to mental disorder and crime, namely ‘Criminal’, ‘CPSA’ and ‘civil’. The final heading reflects on culpability in criminal proceedings, the implications for human rights and participants’ perspective on credibility of the legal framework in addressing these issues.

Criminal procedures

Participants echoed the Millan Committee’s views (Scottish Executive 2001c) about failings of the mental health system, in responding to the needs of MDOs. Cases raised by participants reflected concerns about suicide risk in prison, relapse of illness even where a person’s mental well-being was stable at the time of admission and ill-treatment of prisoners (Buchanan 2000). Prisons could not impose medication on those who were reluctant, and the perception that prison authorities were unwilling to have a role in enforcing medication, led Millan to recommend that: “Urgent consideration should be given to the possible need for appropriate services, offering intensive support to prisoners or patients at high risk of self-harm, as an alternative to admission to the State Hospital” (Scottish Executive 2001c, p336). Importantly, at this time where there were no medium secure units in Scotland, so not only was the State Hospital seriously overcrowded, but entrapment was also problematic, as routes for discharge were limited and the options for less severe offenders to be securely managed elsewhere, even more so. Millan (Scottish

Executive 2001c) also urged the avoidance of prison for other vulnerable groups particularly women with personality disorder and people with learning disability.

In the review of literature, the justification for detention and compulsion was examined, in relation to civil and criminal based mental health legislation (Greig 2002; Bean 2001; Hoyer 2000; Prins 1995). Discussion amongst participants reflected many of the issues identified and although, largely in agreement that people with mental disorder were poorly served in the prison system, many participants believed people should face the legal consequences of their actions. One Area 1 MHO acknowledged public safety concerns, but remained uncomfortable with the severity of a three-year sentence imposed on a man with schizophrenia for threatening a taxi driver with a knife. The greatest concern was reserved for repeat 'offenders' where it was perceived that the seriousness of their offences was escalating and no consequences ensued for the perpetrator. Bean (2001) and Prins (1995) seemed quite clear that compulsion and detention could be justified in such cases (less so where the risk was to self), but from participants' accounts it appears that the legislative framework is avoided at times, often with limited justification.

Very differing perspectives of professionals emerged when discussing case examples led by participants. In one example a consultant psychiatrist excused domestic abuse on the basis of mental disorder, a view not shared by participants. Another participant explained how strenuous efforts to bring a man to court over repeated concerns about his behaviour were thwarted when the Sheriff immediately discharged him on the grounds of perceived vulnerability. Another participant noted that even if treatment were a condition of probation in her experience the order

would be discharged too quickly. This again highlights situations where legal remedies may exist, but gatekeepers outwith social work services adversely affect participant's ability to intervene.

There was substantial evidence from all groups that ordinary criminal procedures are rarely used for people who are obviously mentally disordered, the preference being for informal, civil or more rarely CPSA responses. Most participants believed that straightforward criminal procedures should only be used if there was no direct link between the mental disorder and the crime, though to some extent qualified this when major mental illness was present. In cases of serious criminal acts or escalating situations, where mental disorder was implicated, use of CPSA routes was favoured by many. One participant effectively summarised what seemed to be a majority view thus: "the belief is, it is not in the public interest to bring prosecutions…to bring him into the criminal justice system (meaning CPSA routes), where in fact it might be" MHO42. Wider evidence for this approach is not evident in literature about the Scottish system.

Use of CPSA disposals (the interface between the 2003 and 1995 Acts)

CPSA processes were viewed as desirable by many of those who understood them, because people would receive treatment, a 'paper trail' could be created whereby people posing the highest risks would be identifiable and their offending history would be clear. Participants were generally unfamiliar with these measures, echoing concerns identified in the L and M inquiry about lack of knowledge amongst social workers (MWC 2006c). While participants seemed aware of complexities around risk assessment and management, apart from specialist MHOs their technical knowledge of legal process or of risk assessment tools was limited. The revised MOP (Scottish

Government 2010e), which post-dated the data-collection phase of this study sought to ensure MHOs are adequately trained in criminal procedures and mental health related law and are conversant with current thinking on risk assessment and management, no evaluation of this approach has yet been undertaken.

MHOs in Area 3 seemed most familiar with CPSA processes, the majority favouring use of an Assessment Order for Drew. Interestingly the Area 1 mixed group viewed the CPSA route as very open-ended and for that reason most favoured civil measures. This open-ended aspect of mental health criminal procedures was a particular concern for Bean (2001), who worried about the potential for inappropriate long-term incarceration. While in cases, such as Noel Ruddle, justification for long-term incarceration is clear (Scottish Executive 2000b), in many others, responses were seen as disproportionate (Bean 2001). The Millan Committee itself acknowledged this, believing that the emphasis in the 2003 Act of MHO involvement in CPSA detention and compulsion cases would help keep such arrangements under review (Scottish Executive 2001c). Again these changes, enhancing the MHO role in this case, have not yet been subject to any substantive research.

Participants had little understanding of how CPSA processes related to convictions for serious offences. One participant reminded others that there were at least review processes, which in fact allowed Noel Ruddle to be released only 7 years after being incarcerated for murder (Scottish Executive 2000b). These measures were amended in 1999 and then under the 2003 Act, although rights to review remain intact. Several participants nevertheless expressed ongoing concern about potential entrapment in the mental health system. Despite the commonly held belief that MHOs are experts

in legislation (Keenan 2012), It was interesting that it was a care manager who raised concerns about transfer for treatment directive (TTD) from a rights perspective. She not only could name TTDs, but could provide some valid critical analysis of the process.

Despite a general lack of understanding of the detail of CPSA, most participants favoured a formal response recognising the criminality associated with people's behaviour, rather than simply civil detention. Many examples were given, drawn from community, residential and hospital settings, where the police, sheriff or procurator fiscal had not pursued charges when participants believe they should have done. The CPSA approach was favoured by one MHO on the grounds that forensic psychiatric services are much better at dealing with such matters.

Civil responses

For no apparent reason, the strongest support for civil responses seemed to come from Area 1 MHOs who largely agreed that an STDC possibly followed by a CTO, would be the desired route for Drew. This was partly from a pragmatic point of view, in that the procurator fiscal would be likely to defer any decision or even simply throw out the case, so civil measures would maximise the chance of a necessary mental health disposal. One criminal justice professional identified a slim possibility of combining civil processes with criminal procedures such as probation. There was considerable discussion around what impact the knife would have on the decision to prosecute or otherwise, in the light of changing public policy towards knife crime.

Many participants recognised the value of a 'paper-trail' in ensuring professionals were aware of the history of offending behaviours and were concerned that going

down ‘civil routes’ or worse informal admission might cause such records to be missed. Most participants believed ‘informal approaches’ were the most likely outcome for Drew.

General issues about culpability and access to appropriate treatment

An interesting point was the prominence given by a few participants to access to treatment. The Area 2 mixed group clearly believed that treatment should not be viewed as punishment. The Area 3 mixed group agreed that benefits of a CPSA compulsion order include rigorous review processes and better emphasis on the patient’s ”right to treatment”. In this context, Bell’s (2005) review of the New Zealand system, was critical about the absence of legal obligation to provide services. Hiday et al (2002) examining mental health services in the USA, reflected on rights to treatment and highlight conflicting views between workers seeking protection for themselves and others, and civil rights groups seeking protection for the offender. Participants in the current study expressed frustration at frequent failings of the system to put protection plans in place, both for the benefit of others and for the individual who might receive treatment.

A range of obstacles to treatment were identified, for example in relation to actions of gatekeepers: a psychiatrist who identified co-morbidity of substance misuse and personality disorder as situational and not the business of psychiatry. Although this issue is not directly tackled in the 2003 Act, the inclusion of ‘personality disorder’ in the definition of treatment (s328), the emphasis on advocacy (s259), patient and carer involvement and consultation, potentially strengthens accountability, which in turn should enhance the right to treatment, for anyone with mental disorder.

Returning to the issue of culpability, noted under the first subsection of this discussion, many participants struggled to decide whether straightforward criminal proceedings should be used for people with mental disorder. Examples were led of people who manipulated the system to try to avoid culpability or believed they were immune to prosecution due to their mental disorder. A few participants believed the issue was often one of lack of self-control, rather than actual inability to control behavior and that it was therefore important that people understood the consequences of their actions. Many participants echoed ideas explored in the review of literature about connecting offending behaviour to mental disorder, before instigating legal interventions under mental health law (Greig 2002; Bean 2001; Prins 1995). These writers expressed concern at the psychiatric system becoming a jailor for those for whom the criminal justice system had no solution. Participants in this study expressed a similar view, but noted that in the absence of an appropriate criminal justice response, psychiatric health services often absolved themselves of responsibility and left social work to deal with these complex cases.

4.9.3.3 Stigma

Stigma seems to belong under the heading of human rights, though it clearly features in other parts of this study. The sources of stigma were explored in detail in the early part of the review of literature. Evidence put forward in the later part demonstrates the need for the law to be more inclusive, to try to ensure people who experienced mental disorder are not discouraged from seeking help because of perceived stigma associated with accepting psychiatric services (Scottish Executive 2006a; 2001c). There were no particular questions in this study, seeking to establish whether the legislative framework succeeded in addressing stigma as an obstacle to accessing services. Perhaps as a consequence, few participants identified

addressing stigma as an issue, but there may be alternative explanations. There is no doubt that those using psychiatric services do experience stigma (Shorter 1997; Wallcraft 1996), further exacerbated by involvement in forensic services (Greig 2002) and social isolation (Campbell et al 2006). Social work tends to work with the most 'stigmatised' groups anyway, so perhaps it is accepted that this is an issue which needs to be addressed routinely. However, there is no doubt social workers do at times behave in a discriminatory manner. The MWC inquiries identified discrimination by social work staff in a number of cases where they undertook investigations: in relation to inaction over reports of rape by Ms A (MWC 2008b); in tolerating poor living standards for Mrs I (MWC, 2010b) and in several cases where attitudes around drugs and alcohol created obstacles to intervention for many professionals.

Those participants who did identify stigma as an important issue cited a number of aspects. In the Harvey case study, several participants believed his parents were discriminating against him and effectively stigmatising him. Associated problems, such as lack of confidence and passive compliance, it was widely agreed, needed to be tackled by educating the parents. Dismissive staff attitudes to peoples' wishes were also identified in the Victor case, which it was feared would undermine his rehabilitation in a real situation. One MHO expressed concerns about the stigma that someone like Drew might face if court processes labelled him as a danger to the public.

Finally, discrimination and stigma were identified as factors in not providing treatment, even when many believed it necessary. Area 2 MHOs were the only

group to identify the stigma attached to the first detention (or compulsory measures) taken under mental health legislation. Discrimination related to substance misuse was reported to be widespread and again undoubtedly within social work as well as other agencies. There was a clear sense from many participants that adherence to the principles of the Act was likely to lead to more ethical, less discriminatory practice, but no comment was made as to the impact of the legal framework in addressing stigma associated with the diagnosis and treatment of mental disorder.The impact of stigma on use of the Act may be operating at a more sub-conscious level and it might be interesting to look at what influences the exercise of powers by NHS and local authority, from that point of view, in future research

4.9.3.4 Conclusions

The broad focus of this theme has been on criminal procedures and deprivation of liberty, both areas where mental disorder may interfere with respect for human rights. The discussion has attempted to clarify how human rights aspects are interpreted when discharging functions and to what extent participants believe the legal framework is credible in addressing human rights issues.

Participants were very conscious of growing concerns over addressing deprivation of liberty under this legal framework. As gatekeepers, local authorities' duties towards groups affected by this legislative framework were extensive, yet it was clear that other gatekeepers, including medical staff, police and prosecutors, frequently prevented participants from discharging these functions. Such obstacles included resource problems, protecting professional boundaries and complex processes for diagnosis, assessment and risk management. Furthermore, participants were very conscious of mixed messages from legislators and regulators around the need to

act, whilst managing resources and avoiding undue restriction, all of which seemed to present almost unmanageable dilemmas. One example of this was the assertion that guardianship under the 2000 Act might be needed to justify deprivation of liberty, but could only be enforced by placing someone in a locked environment, thereby undermining the intention of guardianship to support community living. The issues explored in this theme are linked to findings from earlier themes about use of the Acts, risk and bureaucracy.

Right to treatment also emerged as an important area, in that participants often faced dilemmas between respecting lifestyle choices or intervening to provide care, protection and treatment. Participants argued that drug misuse and other behaviours, including criminal, allowed services to opt out of their duty to intervene. Furthermore, many service providers allowed insufficient time to properly assess complex needs of these groups, leaving care managers, and sometimes carers, to manage without support from these services.

Participants' reflections on human rights and the ethical evidence base for intervention, suggest that there has been some success for legislators in embedding human rights issues, when thinking about use of the legislative framework. Participants generally seemed attuned to human rights aspects of the law, though it could also be argued that their own professional codes of practice are now reflected more closely in the legislative framework. Focusing on deprivation of liberty and criminal procedures elicited a range of views discussed in the review of literature. However, much of the discussion around these areas evidenced real frustrations, where participants felt they had duties of care and protection which could not be

realised due to lack of cooperation from medical staff, police and prosecutors. There were clearly knowledge gaps and 'value' differences among participants as to how issues of criminal procedure and mental disorder are pursued and resolved. Nevertheless, the case study featuring criminal procedures produced stronger reactions and raised wider issues than anticipated and it certainly suggests the complex and difficult issues around criminal procedures would benefit from further in-depth research. An overarching concern spanning deprivation of liberty, lifestyle choice and criminal procedures was a sense that there were many opportunities for services to avoid meeting their statutory responsibilities towards those in need, circumventing what most participants saw as well intentioned efforts by the Scottish Government to develop a more inclusive and fair system.

4.10 Theme Eight: Attitudes to legislative framework

4.10.1 Introductory thoughts

This theme arose from asking participants to express their general views on the legislative framework. In preference to dividing the findings into areas or professional groups, where there were more commonalities than differences, these findings are divided into four areas: the 2000 Act; the 2003 Act; the 2007 Act and finally the overall framework. As in the other themes the discussion of these findings follows immediately.

4.10.2 Findings

4.10.2.1 The 2000 Act

Looking at the Harvey case study CM47 in Area 3 described guardianship as "a bit heavy handed", but CM48 responded that "guardianship is not necessarily punitive it could be life enhancing". Despite this she referred to another case involving

moderate learning disability where use of the 2000 Act was less life-enhancing, and she believed the law undermined good practice, where guardianship, the first course of action, was more like a punishment and : “so restrictive to the woman. I would like to see them do some person-centred work ... there is a real difficulty getting that kind of service” (CM48). An MHO trainer in the group agreed, referring to poor use of Person-Centred Planning as an alternative or as a first line strategy. When the group was asked if this suggested the Act was sometimes used as shortcut to save resources, all present agreed.

Similar views on the restrictiveness and overly bureaucratic nature of the 2000 Act emerged from other groups. An Area 2 team leader, MHO18, argued that for someone like Harvey, using the Act would be like “using a sledgehammer to crack a nut”. Even more starkly, when one group was asked whether earlier noted deceptive approaches to admitting people to hospitals or care homes were preferable to using the legislation, MHO43 stated “to be perfectly honest I think it would have been. I think we went over the score with AWI”. One participant described the 2000 Act as a “cash cow” for solicitors. CM29 was however, supportive of the 2000 Act “I think the AWI offers a degree of protection – going back to how things were I don’t see how we could have protected people, especially from their families”

Mixed views emerged about the impact on family and services, of using legislation to intervene. The Area 2 MHO/CM group debated the relative merits of using the 2000 Act to force issues, as opposed to alienating the family from services; however, inappropriate was their behaviour (within limits). Others argued that making families aware that local authorities could exercise legislative powers might disuade them

from engaging in exploitative behaviour (Area 2 MHO/CM). Area 1 MHOs had similar concerns around the impact on relationships with families, already discussed under the Carers theme.

The Area 3 MHO group identified a local authority guardianship application in respect of a woman with severe Korsakoff's syndrome, where they argued that the patient's solicitor was not acting in her best interests. The Sheriff took almost a year to hear the evidence and decided against the local authority application. Social work managed this hugely complex situation, throughout and after the whole process, with no statutory authority. The woman herself reportedly had no understanding of the process and believed the final written decision was a summons to appear in court.

4.10.2.2 The 2003 Act

MHO43 who had earlier referred to going 'over the score' with the 2000 Act, added "… but not as much as the 2003 Act which is just a shambles … solicitors jumping on the gravy train – all to benefit everybody but the poor person". MHO42 and 41 supported this view, MHO41 arguing that as soon as a solicitor appears at a tribunal, the hearing will be continued, the panel will "need to justify their decision to give an interim order" which they will not refuse as the solicitor will "hit them with a shrieval appeal". An Area 1 MHO described the 2003 Act as a "charter to print money" for solicitors, another in the group adding that the system is dominated by, and favours, lawyers. Although strong feelings were expressed by these participants others were much less exercised about the issue, so it is difficult to quantify opinions on these matters.

CM47 offered an interesting perspective on criminal procedure aspects not picked up by others, in this mixed MHO/CM group: “it is all about the person’s well-being, whereas when you bring in what the philosophy of criminal law is about (Drew case) it is about what is best for the community and it is really about punishment”. An MHO/trainer in this group broadened this perspective to focus on the benefit principle and “…whether treatment is going to help this person. If it won’t help what is the point?” (MHO46).

In the Area 2 CM group one CPN commented that “the only Act that has any teeth is the MHA ...” (CM36). He further asserted that almost no adult mental health service users were sufficiently incapable to justify use of the 2000 Act. Another CPN disagreed, describing difficulties she had trying to persuade a consultant to invoke the 2000 Act, (discussed under an earlier theme). Two other CPNs in this group strongly agreed that a CTO improves engagement of patient and hospital, one noting that a patient they were involved with might have been discharged otherwise (a positive benefit in his view). It was further noted that for some patients when the CTO stops so too does compliance.

4.10.2.3 The 2007 Act

This Act drew most responses from participants, when asked about the legislative framework as a whole. CM47 argued that the 2007 Act does little more than underpin existing practice: “we have been doing this for a long time but now we do things under the ASP”. Many participants argued that the Act was too weak and deployed a range of metaphors to underline their point. In Area 1 CM8 described the 2007 Act as “relatively toothless as a piece of legislation” and revealed that he and the Adult Protection Officer, CM9, disagree on this. Discussion in a different Area 1

focus group reached similar conclusions to CM8. MHO5 noted that after training “I did have a feeling it didn’t have much teeth that was my overall impression”. An experienced MHO team manager agreed stating “it reminds me of these CCOs, they were brought in maybe 10 years ago and there was maybe two or three in a year, I mean it just seems as if it has not got any teeth to it” (MHO6). Despite agreement about weaknesses of the Act many believed that to some extent the 2007 Act filled gaps in the law. In Area 2, MHO25 reported that since the 2007 Act, GPs seemed more willing to share information, though CM29 an NHS employed care manager disagreed, stating that GPs were still uncooperative.

The Area 1 CM group debated the effectiveness or otherwise of the 2007 Act. Two participants regarded the adult protection ‘route’ as a blunt instrument to resolve complex dynamics: “just because you convene an ASP case conference doesn’t mean you are fundamentally ffecting any real change ... the same problems are still there” (CM13). CM15 added that case conferences are counter-productive, “… because any kind of goodwill you are trying to foster is immediately kicked out the door”.

MHO18, earlier reported as likening the 2007 Act to “wading through treacle”, later gave a case example where a son had stolen from his father and despite lengthy discussion at adult protection conferences and with the police, no action was taken. This failure to act on findings seemed commonplace across this and other groups. A CPN in the Area 2 CM group agreed and asserted that the 2007 Act fails to address culpability, citing a situation where one vulnerable person attacked another (a father attacking his son).

In Area 3 MHO41 described their “vulnerable adults policy” as “pretty toothless”. He had outlined difficulties in enforcing a banning order, where a son and daughter were exploiting their Mum, who he believed was “not going to be able to stop her son or daughter coming in”. With regard to this situation, the group were asked if they perceived differences between typical powers under a 2000 Act guardianship determining “with whom a person might consort” and 2007 Act banning orders. MHO43 responded that the 2000 Act powers do “not have a lot of teeth – how could you enforce that, however, a banning order has slightly more teeth, there are consequences if you breach it”. CM15 reflecting on enforcement processes, stated that if meeting with resistance, as an ”absolute last, last resort...you would have to (use the 2007 Act)...if...they were resisting it tooth and nail and you could see that they were having a really negative impact on the individual ... it might be enough to really kind of emphasise how serious you are”. M16 agreed that this “threat of use” might be enough to change minds.

Despite concerns about enforceability, many participants believed that the 2007 Act had instigated significant change. MHO2 in Area 1 believed it had “profoundly” changed the way people think. Whilst acknowledging no orders had been used, the underlying ethos had created “a major shift in the words people use, the way they go about it, what we have got in our head now is a different model so there has been I think a major culture shift”. MHO3 agreed and MHO2 added that professionals are now fearful of “getting it wrong”, which he did not necessarily see as negative. MHO4 added that the 2007 Act provides “a very clear legal framework” within which social work practice operates and “makes us much more accountable”.

The earlier noted expansion into working with people with substance misuse problems was regarded positively by the Area 1 MHO group. Several of this group regarded the 2007 Act as helpful because it extended the range of interventions, subject to some of the limits discussed earlier. However, MHO4 sounded a note of caution stating “we are not buying into it, we are being forced to do these things by legislation and it does appear that the Scottish Government want to introduce more and more legislation, which they do repeatedly as we know, so that in the end if things go wrong they can say you had all the acts and the resources to do something about it”.

The Area 1 CM group expressed serious concern over heightened expectations arising from a 2007 Act advertising campaign, which they suggested give the impression that “legislation can be brought to bear on just about anything – instead of a last resort – terrible advert terrible” (CM16). CM13 agreed strongly, citing difficult discussions with families who wanted something done after seeing such adverts. Although not highlighted by others this recalls an earlier reported comment that social work had become accountable for matters over which it had no control.

4.10.2.4 The overall framework

There seemed to be a generally benevolent attitude to the overall framework: for example, when asked the MHO/CM group in Area 3 agreed that the framework helps in their day-to-day work, or “mostly”, as MHO45 put it. However, although expressed in a humorous manner, observations by two participants should not be ignored as they imply disengagement from the legal processes by a few. CM13 argued that whilst the 2007 Act may help with the vulnerable, but ‘capable’, generally “the Acts

are good but they are no substitute for good old fashioned social work". CM7 observed that "all the cases (case studies) need adult protection and the law doesn't make one iota of difference", similarly implying that the legal framework is unnecessary.

In a more constructive manner, significant doubts about many specific aspects were widely raised. The Area 2 MHO/CM group, like many others, thought that "traditional" social work interventions were more appropriate in Harvey's case. One participant commented "I think legislation is used as a substitute for decision-making" (CM28), advocating informal means of intervention first. However, some of this group thought that the 2000 or 2007 Acts could provide a framework for reflection and for decision-making. Two MHOs supported each other in asserting that the framework is good for future planning.

A range of views were expressed in response to a direct question about perceptions on effectiveness and cohesion of the framework. CM24 and MHO27 from the Area 2 CM/MHO group regarded the framework positively, seeing it as "a good idea" (MHO27). CM23 added that it "makes you discuss cases more fully", but thought it did not go far enough, especially the 2007 Act. Alternately, CM28 was particularly impressed with the 2007 Act. CM24 perceived the 2007 Act as gentler, perhaps intended to encourage people to do more for their own protection. CM22 argued that measures across the board to allow urgent intervention were inadequate and that although the 2003 Act contained urgent measures, the strict criteria limited situations in which they could be used. Despite the apparent emphasis on 'benefit', CM24 argued that the outcome of using legislation was sometimes detrimental. CM26

agreed, adding that GPs seemed distanced from the framework; lacked knowledge and abdicated responsibility. CM23 and CM24 agreed, suggesting this indicated a need for more joint training with NHS.

When asked to focus on utility of the legislative framework in their day-to-day work the discussion mostly centred on the 2007 Act. CM12 (a hospital-based CMHT worker) made little use of either the 2000 or 2007 Acts, but acknowledged the latter seemed useful, not for protection orders, but in getting people together and sharing information. MHO8 agreed, and suggested that the term 'adult protection' engenders a different response "you will get people round the table much more readily". CM7 argued that the 2007 Act lent a higher profile to adult protection and helped extract information from banks and others. CM12 thought that is was more than just language and that now "there seems to be a bit more of… I won't say commitment – fear - that if you don't come – oh dear". She also suggested the 2007 Act "allows you through the door" quicker than other Acts. MHO10 a MHO team manager, regarded the 2000 and 2003 Acts as useful, but deemed the 2007 Act as mostly irrelevant for MHOs. CM11 stated that there was less consultation with the 2000 Act than the later Acts, leading him to view the 2003 and 2007 Acts as more "user-friendly". He perceived the overall framework as mostly coherent, but like others believed 2007 Act "orders" were not working. He suggested this may be linked to uncooperative sheriffs and might therefore improve over time.

The Area 2 MHO group were in agreement that the framework helps reach resolutions in difficult cases such as Victor's. MHO20, a newly qualified MHO, worried about the restrictive nature of the framework, but MHO19 argued that this is

beneficial: “at least processes are a bit more robust especially when people have dementia and can’t speak for themselves”. At organisational level he argued that the framework provides strategic direction “where services are not working and things keep falling apart” (MHO19). The group agreed that the framework could help local authority fulfil their duties, but also noted that most staff lacked confidence and needed greater awareness of options and links between the Acts.

Somewhat provocatively, a CPN, CM35 stated that “the legislation actually won’t achieve anything you are hoping to achieve for the person”, though tempered this by conceding it might help in some circumstances. The case example she cited in this context related to “someone who is really quite vulnerable at some levels” but did not fit any of the Acts. She referred to social work, housing and health as “ ... helpless to do anything” and argued that the usual processes would not change outcomes for people such as him. In the same group CM32, referring to the Harvey case, observed that care needed to be taken in planning interventions, to avoid jumping in, whether by means of this legislative framework or otherwise: “watching as well that you do not go in and kind of bulldoze this family ... end up potentially …” finished by CM35 “… alienating folk”. A similar comment about alienating families was noted under the diagnosis theme.

4.10.3 Discussion

4.10.3.1 Introductory comments

As with the findings, this discussion is split into four different sections, one for each Act and one examining the overall framework. These findings represent direct responses to a question, rather than more considered or ‘embedded’ views,

expressed and explored through other themes. Nevertheless, these more immediate responses potentially provide valuable insight into participants less guarded responses. Limited attempts are made to quantify responses, but these can only be impressionistic, since some participants responded with explicit statements and others either supported these statements with nods or dissented verbally, non-verbally or simply by failing to challenge.

The 2000 Act

Reflecting on the responses when asked about the 2000 Act, it is certainly necessary to acknowledge the surprisingly negative perspectives before moving on to specific issues which need to be considered. Several participants used strong, negative metaphors to describe processes (blunt instrument, sledgehammer to crack a nut), added to which emphasis was placed on the heavy handed or restrictive nature of intervention, ideas about punishment and preference was expressed for informal means or 'traditional' social work approaches. These perspectives reflect some of the debate about justification for detention and compulsion (Atkinson 2006; Bean 2001) and perhaps more importantly suggest that participants are yet to be convinced that these legal interventions are the best approach to managing incapacity and mental disorder. As noted at the outset of this section it is difficult to quantify how many people hold these views, but these views were not uncommon.

Most participants did however, see a positive side to the 2000 Act, for example one aspect specifically identified by several participants and supported by many others, was that the 2000 Act helped to prevent families from abusing their relatives. This form of abuse emerged throughout the review of literature, from Elizabeth Packard

(Packard 1865) to numerous MWC inquiries including Mrs T abused by her son (MWC 2007b) or Mr H exploited by his daughter (MWC 2006b).

Frustrations about slow processes associated with the law were common, already highlighted under other themes. The review of literature (OPG 2011; Patrick 2008; Killeen et al 2004) echoed these concerns, but no significant changes to the 2000 Act have occurred, other than the introduction of 13ZA, which has had a major impact on the 2000 Act, but is in fact an amendment to the Social Work (Scotland) Act 1968. This was principally responding to resource pressures, and intended to save time for regulators, who monitor the arrangements, for doctors who provide reports and for local authorities who have had to commit significant staff resources. As noted under earlier themes, many participants believed 13ZA, was not legally sound, and had in fact turned back the clock, undermined human rights and led to greater use of deception.

Many participants viewed the 2000 Act as income generation for solicitors. Lawyers certainly had the lead role in decision making for those lacking capacity or requiring treatment in the 18th and 19th centuries in Scotland (Houston 2001) and medical professionals were simply witnesses in the process. Despite considerable changes to processes since then, this legislative framework still requires considerable input from lawyers. Social work and psychiatry clearly still need to work out an effective relationship with this profession. Whilst caution should be exercised in accepting the level of criticism directed at lawyers, whether for exploiting the processes for financial gain, or failing to make proper checks related to power of attorney, as in the Mr and Mrs D case (MWC, 2012h), these views are clearly based on their

experience and should not be dismissed. Earlier noted failings in local authority legal sections to adequately support staff should also be addressed.

The 2003 Act

The theme of legal domination was again very evident and many participants emphasised an exploitative view of lawyers' motivations, rather than one which upheld peoples' rights. Frequent avoidance of using the 2003 Act to underpin hospital admissions was viewed as problematic by many participants and differing examples were led across the groups as reported in previous themes.

Whilst there were mixed views around enforceability of the 2000 Act, many believed the 2003 Act does have "teeth", largely viewed as effective means of reinforcing interventions. Several participants believed CTOs prompted compliance from patients, but additionally according to one participant, ensured health authorities compliance in discharging their duties such as, keeping patients in for longer, reserving beds whilst on trial visits home and deploying more services. Whilst this might be viewed positively, it raises the question as to whether those not subject to the 2003 Act get a poorer service. This potentially undermines principles intended to ensure that no undue disadvantage results from *not* being subject to the Act (s1(3)(g). Rather unhelpfully, the Code of Practice (Scottish Executive 2005d) does not expand on this principle.

Reflecting further on the principles, one participant questioned whether the benefit principle (2003 Act, s1(3)(f)) can really be satisfied, given extensive failings in hospital and community care. Use of the 2000 or 2003 Acts, as a short cut to facilitating admission to care or hospital, seemed commonplace. Scull (1996)

graphically identified the failure of institutions to provide therapeutic support, suggesting somewhat controversially that many were simply “well-tended cemeteries for the breathing” (Scull, 1996, p7). Furthermore, many have questioned the effectiveness of community alternatives (Coppock and Dunn 2010; Rogers and Pilgrim 2001; Wallcraft 1996) and small scale, apparently intensive housing support has also been subject to significant criticism (Brown 2006; Williams 2006). The question then arises as to whether any real change has come about, or as Wallcraft (1996) suggests, the concept of hospital treatment has simply been transplanted wholesale into the community without consideration of how to do things differently. Comments from many participants reflecting the ongoing dominance of psychiatrists under the new legislative framework, suggest this may be a problem in the Scottish system.

Several participants reported that adult psychiatric services regard the 2003 Act as relevant to their day-to-day work. It was argued that the 2000 Act is for older people and learning disability and the 2003 Act is for the mentally ill, furthermore one CPN from adult services did not think anyone on their typical caseload would lack capacity in terms of the 2000 Act. Another participant referred to difficulties in trying to invoke the 2000 Act, when she believed it was necessary, but the psychiatrist believed that it did not apply. Two important issues previously noted are again highlighted here: firstly, the legislative framework is apparently not seen as a ‘framework’ and is compartmentalised by some, in terms of diagnosis and user group. Secondly that, with the psychiatrist as the gatekeeper, significant problems can arise for staff trying to use the legislative framework. Whether in relation to the 2000 or 2003 Act, without support of the psychiatrist, as one participant commented, social work is left “holding

the baby". It appears that indeed "the professional [and especially] medical hegemony in the mental health system" (Coppock and Dunn 2010 p124) continues to dominate.

A care manager introduced an interesting discussion about shifting from a "well-being of the patient" approach to "punishment" and "community protection" when criminal procedures were invoked. Whilst this somewhat over-simplifies the link between CPSA and the 2003 Act, she identified an important consideration in the literature. Prins (1995) and Greig (2002) highlighted political influence in the way that such legislation is invoked, especially in terms of the 'mad' versus 'bad' dynamic. It is not clear from commentary on the 2003 Act, or from participants, that the 'dilemma' of whether to use civil, criminal approaches or some combination, has really been addressed and the current study reveals a range of views amongst professionals. This discussion was reported on more fully under the Human Rights theme.

The 2007 Act

Most respondents cited issues about the 2007 Act when asked general questions about the legal framework. Given this was the most recent Act and nearly all training identified by participants related to it, this was unsurprising. The level of negativity about the Act was however, unexpected. Metaphors deployed by many, such as "bulldozing the family" (also identified by Ekosgen 2013), referred to the indiscriminate way use of the 2007 Act impacted on individuals and families and on their relationship with social workers. More positive ideas about the Act emerged on further discussion, when applying the framework to the case studies or describing actual cases.

Rather contradictorily, a few participants believed that the Act was too weak, as a result of which abusers too often escaped unpunished. They found police and procurators fiscal generally unwilling to act against abusive family members or against perpetrators, who were themselves perceived as vulnerable. In contrast a few participants welcomed coercive aspects of the Act, whereby banks were more likely to cooperate in sharing information and some kind of “threat” could be held over perpetrators of abuse. Although a few participants commented that cooperation with GPs had improved, one participant asserted that GPs continued to be as uncooperative as ever. Many participants felt the Act facilitated round table discussions with other professionals.

Views may have varied about the coercive or otherwise nature of the 2007 Act, but for many, the bureaucratic aspects were frustrating. Given the long run-in to implementing this legislation, this might be viewed as an administrative failure. As noted in the review of literature, originally intended to be part of the so-called three pronged approach, the proposed Vulnerable Adults Bill (SLC 1997) disappeared, to be revived much later, following the Borders inquiry (SWSI 2004). Rather than achieving the original aim of enabling intervention with those not covered by the 2000 and 2003 Act, many participants regarded the resulting legislation as ineffective in terms of the stated aim of protection, overly intrusive and much more widely used than envisaged in undertaking investigations. However, several participants did say that the Act had filled a gap, and the possibility of more robust intervention with abusers was seen positively, so views were clearly split on these matters. The biggest reported changes around practice (though one participant

claimed the Act merely formalised what was already done in practice) related to the previously noted widespread use of investigative powers under s4.

Banning orders were regarded positively by several participants, on the basis that they believed these to have “more teeth” than similar powers under the 2000 Act. Powers of arrest are attached to banning orders (2007 Act, ss19-34), however, participants did not seem to realise that these powers are ‘situationally-based’, in that a person may only be banned from a place ‘occupied’ by the adult, whereas with guardianship or power of attorney it is possible to include a measure to bar all contact with someone seen as ‘undesirable’, though the power to enforce is less robust. This reflects participants’ incomplete understanding of the law but also highlights lack of consistency across the legal framework.

Many participants believed the 2007 Act has changed attitudes to adult protection resulting in greater accountability and greater clarity over how to intervene. Tied in with this accountability, several participants referred to being pressured by their own management to use the law, recognising that in turn similar pressure was applied by government to local authorities. A few participants regarded this as part of an increasing blame culture, whereby government or regulators provide legislation and use lack of compliance with the law to divert blame from themselves onto local authorities. Participants in MacKay et al’s study on the 2007 Act (2011) made remarkably similar comments. It is difficult to see such comments in a positive light, except perhaps that these measures have engendered greater engagement with the adult protection agenda from senior management.

Given its apparently understated and very limited powers, the 2007 Act seems to have dominated the political and social agenda for adults at risk since it was enacted. Participants seemed very aware of this and anticipated many of the issues raised by commentators in the years following the data-collection phase in 2008-9. Writers commenting since then (Patrick (2012, 2009; Mackay et al 2011; Loxton, Shirran and Hothersall 2010, MWC 2006b – 2016b) all reflect on the dominance of apparently risk-averse and risk focused policies that have emanated from this Act and inaction in respect of the 'Support' element contained in the title. Available statistics about the 2007 Act demonstrate high numbers of inquiries and investigations and huge variations across the country. It is otherwise difficult to comment on use of other measures under the Act as there is no national record other than Ekosgen (2013) and individual local authority bi-ennial reports of Adult Protection Committees which record information in different ways.

Given the wide-ranging use of this Act and associated widening groups of people now brought into the social work sphere, including those with substance misuse problems (as evidenced by participants input), questions might also be asked about how far this Act promotes human rights as intended under the principles. Commentators have had little to say about this so far, although human rights concerns were seen to be one of the reasons why the Act was delayed in coming out in the first place (Atkinson 2006).

A final noteworthy point about the 2007 Act relates to public perceptions. As already noted managerial expectations seemed to have increased in terms of reducing and managing risk, but so too public expectations according, to one participant,

supported by most in her group. There was unanimity in this Area 1 group that the advertising campaign launched in late 2008 was “stupid” and had unrealistically heightened public expectations.

Overall legislative framework

When referring to the overall framework participants frequently adopted a position of cynicism and wry humour. Participants’ views repeatedly reflected beliefs that it is restrictive and repressive, exemplified by earlier noted metaphors, and often described families as alienated and angered by legal processes. This suggests a worrying possibility that the system is ‘backfiring’, as Wexler (2000) suggests many mental health systems do. However, Campbell and Davidson (2012) describe social workers as being uncomfortable in attempting to achieve a balance between empowerment and care on the one hand against control and coercion on the other. If this is the case perhaps negative views are less about the actual framework and more about the inherent conflict in their role. Participants’ views were certainly contradictory, since the same groups referring to the framework as “restrictive” and “repressive” also describe it as “toothless” and “ineffective”, particularly with reference to the 2007 Act. This paradox was evident in MacKay et al’s study (2011) where participants variously described measures under the general framework as “robust” or “poorly defined”.

Even more contradictory is that despite cynicism apparent when reflecting on the identified themes, when asked directly about the overall framework, most participants took a more benevolent view of the framework and saw it as a good thing. Many participants thought the framework was improving communication, enhancing decision-making processes and helping to resolve complex situations. A

minority of those who expressed views, thought little had changed, a few regarded the law as largely process-driven and that it did not achieve the goals or outcomes expected. Of course it is always likely that the interface between complex human social problems and the law is going to be controversial, and views on this will vary, depending on the personalities involved. The concept of 'therapeutic jurisprudence' (Wexler 2000) used by the President of MHTS to explain the role of the tribunal (Morrow 2012) reflects his aspiration that such law should differ from criminal and indeed civil law, as it is intended to incur therapeutic benefits. Most participants were clearly aware that despite this therapeutic intent, the 2000 and 2003 Acts are the only pieces of legislation which can result in an adult being deprived of their liberty without having committed an offence.

On a final note, when asked about the overall framework, many participants were concerned about lack of urgent procedures. The 2003 Act certainly contains urgent measures, but these are subject to very tight criteria (ss36, 44, 112, 113, 114), which many participants claimed resulted in failure to intervene when people were becoming mentally unwell, a commonly cited concern of close relatives (Scottish Government 2009b; MWC 2009d, 2007c, 2006b; Scottish Executive 2001c) Neither the 2000 nor 2007 Acts contain urgent measures, which can be imposed without recourse to court action, although investigative powers and powers to gain access (under the 2007 Act) can be implemented more quickly, depending on local arrangements and policy. This local variation, alongside concerns expressed by many participants and commentators, suggests with some justification, that urgent measures should be reviewed.

4.10.3.2 Concluding links to the current study

As noted at the outset of this theme, extracting accurate quantitative data is difficult, however, some trends were evident. Professional grouping seemed to have some influence over responses. Those working with learning disability, physical disability and old age, were more likely to be using, and interested in, the 2000 Act, whilst for participants in adult mental health services the emphasis was on the 2003 Act. Knowledge seemed to be more closely related to experience of using legislation, rather than specific training, so participants from adult mental health were most knowledgeable about short and longer term compulsion under the 2003 Act and those from other service areas were more knowledgeable about guardianship and powers of attorney under the 2000 Act. Awareness of the 2007 Act was high and views were mixed about its usefulness. The 2007 Act did not appear to be used for one user group over any other, though it reportedly widened the net for potential intervention. MHOs responses here and elsewhere under other themes, suggest a few were becoming disengaged from the 2007 Act.

MHOs clearly had better knowledge of the 2000/2003 Acts and seemed most at ease with exercising legal powers. It was apparent that MHO's views differed from other staff groups but also from each other. Adult mental health service workers, particularly NHS employed staff, had least knowledge and involvement in use of the legislative framework, whilst care management teams, were more familiar with legislation and NHS and local authority staff worked more closely. Trainers, development workers and managers were generally more positive about the legislative framework, though this is more impressionistic given small numbers and the fact that responses were in a group context. The views of trainers and development workers were not always in line with those of frontline staff and there

were several occasions where opposing views were expressed or there was open disagreement. There was wide support for joint training across agencies to address misunderstanding and foster better working relations.

Several points emerged or were further emphasised when commenting directly on the legislative framework. Whilst many regarded the framework as intrusive and at times heavy-handed, many also commented on the potential to improve communication and to intervene with people, previously overlooked. This included those who were reluctant to engage or families who were reluctant to allow access. In direct contrast, many participants perceived a lack of robustness in legal processes, tying the hands of practitioners to intervene effectively, for example lack of urgent measures across the framework was seen to be a problem.

Finally participants expressed a range of views as to who actually benefits from this legislation. At government level, politicians could benefit from blaming practitioners and local authorities for failing to comply with legislation when things go wrong. Similarly managers might use legislation to underpin a blame culture, alternately managers might be comforted by legislation which guides good practice. Many participants believed that lawyers benefitted substantially, although some argued that this was a price worth paying for respecting human rights. Practitioners benefitted from accountability, which many participants believed gave them authority and a degree of power to intervene. For those subject to legislation, benefits included better access to treatment, improved rights to appeal and protection from exploitation. The relative balance of these benefits was the subject of considerable

debate, though most participants believed the benefits for service users were considerable.

4.11 Overarching Issues

The views outlined under the last theme do not fully reflect the deeper issues, which have emerged across the thematic areas. Briefly paraphrased, looking at knowledge and use of law, the 2000 Act is viewed as having great potential to facilitate positive interventions and there is agreement that it has brought together complex, disparate legislation, however, interpretation of certain elements such as deprivation of liberty has presented many unanticipated dilemmas. The 2003 Act reforms have largely been welcomed and matters of interpretation were generally viewed as less controversial. The 2007 Act still very new at the point of data collection, now appears to be a gateway to intervention under the entire framework, despite widespread concerns about the inadequacy of its measures.

Looking at other themes, important issues have emerged concerning the involvement of relatives and aspects of risk management which bring very fresh perspectives to consideration of the overall framework. Participants' concerns about aspects of bureaucratic process and human rights were also expressed with considerable force across a surprisingly broad range of issues. The literature review to some extent anticipated issues that were likely to arise in relation to diagnosis, treatment and capacity, though the sophisticated level at which participants engaged with these issues might also be regarded as surprising.

The conclusions section which follows, amalgamates the complex range of ideas expressed throughout this analysis and extracts specific and hopefully useful recommendations directly linked to the aims and objectives of this thesis.

Chapter 5

Conclusions and recommendations

5.0 CONCLUSIONS AND RECOMMENDATIONS

5.1: INTRODUCTORY COMMENTS

This Chapter brings together the conclusions and outlines recommendations, based on analysis of all the data presented.

5.2 CONCLUSIONS

5.2.1. Introduction

As with much research this has been an iterative process (Srivastava 2009), consequently the findings go beyond the original aims and objective of this research. For ease of reference the conclusions are grouped under the original headings, outlined in the aims and objectives and brief links are made to the review of literature and the underlying discussion.

5.2.2 Participants perceptions about credibility of the legal framework

This framework considerably widens the groups of staff involved and extends the scope of mental health law, resulting in major changes in working practice and expectations. Establishing participants' views on the credibility of the framework helps identify those areas practitioners are most likely to respond positively towards and areas which may meet with resistance.

5.2.2.1 Beliefs about efficacy, risk and outcomes.

Participants largely welcomed the legal framework and viewed it as coherent, at times innovative, respectful of human rights and cognisant of important principles, such as user involvement and least restriction. Most participants believed the law facilitated intervention in difficult and entrenched situations, especially where there

were complex family dynamics. Although participants generally agreed that the Acts complemented each other, there was a tendency to speak about the Acts in isolation from each other. Despite extensive guidance, emphasising the broad scope of the legislative framework, the Acts appeared to have been compartmentalised such that the 2000 Act was predominantly used in older people and learning disability services and the 1995 and 2003 Acts in adult mental health.

Arguably the 2000 Act had the broadest application, particularly when considering anticipatory powers, such as power of attorney. However, it also seemed to be the Act which was least well understood, even at expert level. Patrick (2009; 2008) supported by the MWC (2005) argued that guardianship cannot be used to 'detain' people in community settings, directly contradicting the Codes of Practice (Scottish Government 2011b; 2011c; 2008a). Where capacity was in doubt or low level mental disorder was present legal interventions were often viewed as intrusive and doubts were raised as to the beneficial nature of outcomes. The dominance of medical approaches in terms of diagnosis, assessment and intervention was frequently cited as a problem, particularly in assessing capacity under the 2000 Act, which it was argued should be a multi-disciplinary activity.

After multiple amendments to the 1984 Act, The Millan Committee (Scottish Executive 2001) had sought to bring coherence to mental health law in the new 2003 Act. Given that the later McManus review (Scottish Government 2012b; 2009) only recommended very limited changes, this aim appears to have been achieved. This group of participants were certainly quite positive about the 2003 Act, though Interestingly while community orders, named person arrangements and tribunals

were broadly welcomed, several participants believed that less had changed than was suggested by the legislators (Scottish Government 2009; Atkinson et al 2007, Lawton-Smith 2006).

Where the 2003 Act was perceived as more straightforward and readily enforceable, there were mixed feelings about the 2007 Act. Participants believed it had introduced greater accountability and a sense of corporate responsibility for adult protection. Inquiries and investigative processes were widely viewed as heavy-handed, bureaucratic and overly focussed on creating a paper-trail to justify existing practice. Furthermore, many argued that the 'Support' element of the 2007 Act has little legal status, and indeed tended to be used when considering alternatives to using the law.

Although the 2007 Act broadly applies to those at risk of harm or self-harm, it appeared the emphasis was on protecting people already meeting criteria for the other Acts in the framework. Many regarded the actual measures under the 2007 Act as unworkable and argued that it has become a gateway to other legislative or care interventions. The headings for the following sections bring some order to the complex and rich discussion amongst participants when reflecting on their beliefs about efficacy, risks and outcomes.

Diagnosis

Linked to a later group of conclusions about medical dominance of process, participants believed diagnosis underpinned use of the framework and complexities around this were a clear source of frustration for many. One example related to the continuing use of I.Q testing as a principal diagnostic tool to determine access to learning disability services. Reflecting the debate outlined in literature (Coppock and

Dunn 2010, Johnstone 2008, Shorter 1997), diagnosis of mental illness was similarly viewed by participants as controversial, crude and imprecise. Participants reported that doctors frequently refused to diagnose mental disorder in relation to self-harming and dangerous behaviours or to assess people as lacking capacity, limiting the ability of services to use legal measures to respond and protect.

Despite mass de-institutionalisation, institutionalised behaviours reflecting Goffman's classic theories (1968) were identified. Participants identified case examples where people behaved in certain ways to achieve discharge or admission to hospital or to gain access to treatments, thereby confusing and confounding attempts to use the framework to promote independence. Negative and possibly exaggerated perceptions of these behaviours amongst doctors reportedly reduced their motivation to support use of legislation.

Blame culture

Many participants believed the earlier noted increased accountability, not least of the 2007 Act, was located disproportionately with social work departments. Described as a 'new anxiety' this accountability often concerned areas over which professionals had no control, especially where the law was not used. A few suggested that rather than facilitating effective intervention, this legislative framework 'shields' Government and senior managers from blame. Consequently, if something goes wrong there will be someone to blame, on the grounds that 'the tools' were provided, but not used. Participants in MacKay et al's (2011) research drew similar conclusions and both studies agreed social work often takes the blame. Whilst the MWC have lobbied for change and do provide helpful good practice guides, the emphasis of their inquiry

reports, as demonstrated in the review of literature, often focus on failure to use the existing framework and provide limited advice for practice improvement.

Risk processes

Linked to these concerns about blame culture many participants argued that raised expectations arising from the 2007 Act are unrealistic. Whilst practice examples were led demonstrating how risks can be significantly eased by using legislation, more often the complex areas of risk described by participants were mired in disagreement and conflict. Consistent with the literature, participants largely believed legislation and risk tools could assess, but not predict risk.

Although the literature examined noted that risk has become an increasingly technical activity (Webb 2006; Castell 1991), few participants used formal risk assessment tools. In general discussion, participants favoured positive risk-taking, so-called defensible rather than defensive practice (Robertson and Collinson 2012; Titterton 2005), but in case examples led the emphasis was more on defensive practice and risk aversion. Where social work management responded to interventions by regulators or complaints from articulate carers, this was frequently characterised by un-necessary tightening up of processes and reduced autonomy for staff. Oddly whilst reflecting on this, participants suggested the current culture is very risk-averse, yet the processes to deal with risk seemed much less robust.

Debates reported on in the literature about achieving an appropriate balance between personal freedom and duty of care, were reflected in participants responses to the case scenarios and the associated case examples they raised. There was broad agreement on the range of risks identified within the scenarios, less so on the

potential solutions. It was highlighted that whilst 'others' attitudes to risk affected outcomes, the attitudes of those potentially subject to intervention were also important. Participants were clear that higher levels of risk are tolerated where a person was well known to services, especially in terms of offending behaviour and that this put others in the person's care network (formal and informal) at risk. This reflected similar concerns identified in The Mr F report (MWC 2009d). Many participants were concerned that only the 2003 Act contains meaningful, urgent measures.

Lifestyle choice

Participants found legal terminology relating to risk unhelpful in drawing a line between lifestyle choice and illness-driven decisions. Many examples were led to evidence medical practitioners' belief that self-neglect is a lifestyle choice, where active self-harm, and particularly risk to others, was more likely to engender a legal response, as highlighted in several inquiries (MWC 2012e, 2012f, 2011b, 2010b, 2006b). Even in these cases, where alcohol was involved or impairment was less severe, participants struggled to persuade medical gatekeepers to accept high risk behaviours were driven by illness or incapacity, as opposed to lifestyle, thereby obstructing potentially beneficial legal intervention. With regard to self-neglect although actual harm may be greater, participants thought the chronic nature of self-neglect partly explained reluctance to intervene.

Family involvement

Whilst there were concerns about the negative impact of intervention on families, there was also recognition that abuse was common within family groups and the legislation offered some previously unavailable opportunities to intervene. Many were concerned about the legislative and policy imperatives to encourage relatives

to assume legal powers (under the 2000 Act) as this can create a dangerous concentration of power and can lead to conflict between patient and carer (Rogers and Pilgrim 2001). Many powerful metaphors were used to describe the negative impact of legal intervention; prompting several participants to argue that legislation should be a last resort. Many argued that complex legislative processes undermined aspirations to involve and empower families, furthermore lax supervision of processes potentially left adults at risk of harm from unscrupulous individuals, as exemplified in the Mr and Mrs D inquiry (MWC 2012h). Whilst there was widespread agreement that powers should be removed from such individuals, participants were concerned about the weakness of powers available to local authorities to intervene.

Perceptions of efficacy

National data in relation to the framework is limited to use of Part 6 under the 2000 Act and compulsory measures under the 2003 Act, but none is collected in relation to the 2007 Act, to other parts of the 2000 Act or activity in relation to named persons, advance statements or inquiries. Despite a commitment to do so (Scottish Government 2008a), no data has been gathered on 13ZA. There are few qualitative studies on the legislation and only this study examines the overall framework from the perspective of those responsible for its implementation. Consequently, it is difficult to make definitive statements about effectiveness. Whether this legislation 'backfires' as Wexler (2000) suggests many mental health systems do, remains unanswered, Whilst, participants were sceptical about Government claims of effectiveness in relation to the overall framework, their comments about its day to day use, alongside existing literature, suggest that there is a coherent base from which the framework addresses care, treatment and protection issues. Nevertheless,

the data collection strategies for this legislative framework would very much benefit from review.

Avoidance of appropriate legal measures

Serious concerns were expressed about wilful avoidance of legal measures for reasons of expedience and convenience. This was regarded as both an ethical problem and a failure of process. Participants provided numerous case examples where processes for assessing capacity were rushed or based on limited information, when clearing a hospital bed was the priority. Considerable management and hospital-based pressure around delayed discharge was cited by many as a driving force. Discharge from hospital could be authorised by the 2000 Act, 13ZA or informal means of persuasion, whichever was fastest, regardless of the adult's capacity to decide. The 2000 Act established a clear framework for decision-making around incapacity (SLC 1995), yet this study demonstrates, through literature and input from participants, that guardianship was avoided even before the introduction of 13ZA. Guardianship processes were deemed slow and cumbersome by Government and other stakeholders, so eventually official guidance culminated in the introduction of 13ZA, regarded by many, including the majority of participants in this study, as providing inadequate protection of rights (Scottish Courts 2007, 2004; Ward 2007; MWC 2005, 2004; ECHR 720 2004) Even in the three areas under examination, interpretation and use of 13ZA was quite different. Many participants believed the advent of 13ZA has made it even more difficult to persuade hospitals that legal measures are required to authorise care admissions, where adults lack capacity to agree.

Concerns over avoidance were not restricted to the 2000 Act, as many participants reported similar inconsistency in using the 2003 Act. Again decisions seemed driven by expedience rather than by rights-based approaches, whereby only the most resistant patients would be detained, the remainder would be 'encouraged' to remain. So for decisions relating to in-patient psychiatric care and care home placements it seems legislation is avoided for those assessed as compliant. Many participants reported this preference for informal measures amongst practitioners, their own managers and other agencies. Parallels may also be drawn as to why CPSA measures are used less than might be expected, in that civil procedures may be easier for police and prosecutors. Oddly despite concerns about failure to use legal measures and defend service user's legal rights, substantial ethical concerns about solicitors' motivation were frequently identified by participants, echoing suggestions that the general complexity of the whole legal framework has created a money-making scheme for lawyers (MacKay et al 2011; Dawson et al 2009b).

One further point about use of appropriate legal measures relates to use of investigative processes. Staff felt pressed by managers to use inquiry and investigation processes under the 2007 Act, even where the legal criteria were not met. Despite having the least guidance and the most limited range of measures, the 2007 Act is the most widely used for investigative purposes as evidenced by statistical information and input from participants. Scenarios were led which raise concerns that ordinary human behaviour can be "pathologised" as abusive.

There were mixed views as to why correct legal procedures are avoided, many attributing this to complexity of legal processes, but a few regarding it as more wilful

disregard of what are perceived as onerous processes. It is likely to be a combination of the two, but may also reflect widely held perceptions that such overly bureaucratic processes cannot address the wide range of risks which are targeted. Participants' reports of wide-spread avoidance of the law are not reflected in literature, but if replicated elsewhere this could explain local variation in use of the law. This is an area that would benefit from further research, though clearly trying to understand why due legal processes are not being followed might meet with resistance, so the nature and ethical standpoint of any such study would need to be carefully considered.

Achieving outcomes

There was a mixed picture in terms of whether participants believed this framework helped discharge their responsibilities to service users. One or two expressed frustrations with the new framework, preferring old ways of doing things, but most were able to identify benefits of the new approaches. In more detailed discussion of the case studies and cases led by participants, a range of issues were highlighted which caused ethical concerns or impeded participants' ability to intervene effectively. The few NHS-employed staff involved in this study largely welcomed the framework, but were not in agreement as to their role in terms of finance, managing care or implementing legislation. Examining the operation of multi-disciplinary and multi-agency teams in relation to this framework would be a rich source for future research.

5.2.2.2 Beliefs about the ethical and evidence base of the law.

Patrick (2009; 2008) argues that modern European mental health law must take account of human rights issues such as deprivation of liberty and particularly highlights overuse of compulsion for young people with learning disability. Other

writers identify a general absence of ethical and moral justification for detention and compulsion (Atkinson 2006; Bean 2001; Prins 2001), but there is evidence that those who drafted Scottish law did consider such wider theoretical perspectives (Atkinson 2006; Scottish Executive 2001b; SLC 1997), including user involvement (Campbell and Davidson 2009). However, whether the impact of this legislation on community care was considered is debatable. Several literature sources reflected serious concerns about failures in western cultures to transfer mental health resources from hospital to community and the tendency to transplant hospital-based approaches to community settings (Rogers and Pilgrim 2001; Knowles 2000). There is little evidence in implementation strategies or indeed the law itself that these concerns were addressed in Scotland.

Participants expressed strong views regarding the treatment of people with mental disorder and broadly supported use of informal measures, reserving use of law for the most challenging and dangerous service users. This reflected approaches to mental health law in other countries and commentators' perspective on the Scottish system. (Stevenson, Ryan and Anderson 2009; Atkinson et al 2007; Kisely et al 2005). However, several participants, particularly MHOs and NHS staff, supported wider use of law in upholding service users' rights. Ward (2007) and SLC (2014) expressed similar views, clearly concerned to minimise the impact of moves to dilute the 2000 Act. It is interesting to note that despite apparent support for 13ZA, Patrick (2008) expressed strong views that the overall legal framework needed to better respect human rights.

Mentally disordered offenders

When considering MDO processes there were many parallels with the discussion about failure to use appropriate legal processes. Variation in approaches to use of MDO processes was linked to professionals' views regarding culpability and likelihood of successful prosecution. Participants observed that where mental disorder was present liaison between police, procurators fiscal and social work was poor in relation to understanding motivation and culpability for offending. Such assessments were viewed as ill-informed, inconsistent and lacking in rigour. Failure of these agencies to pursue criminal charges prevented those with mental disorder being held to account for their actions and put service users and potential victims at risk. Two cases examples led by participants highlighted tragic consequences arising from failure to prosecute. As in civil cases, doctors and social work managers were reportedly reluctant to use compulsory civil measures to address complex issues of challenging behaviour and criminality, where substance misuse was involved. Legal measures were so frequently avoided that some offenders apparently believed that their mental disorder rendered them 'immune' to prosecution. This was particularly dangerous, according to a few participants, as this indicated 'insight' and thereby potential culpability. Failure to label people with mental disorder as criminal was believed to have very serious consequences, not least lack of paper-trails to track escalating behaviours. Failure to treat those with the most intractable problems, presenting great risks to society was also a huge concern, a viewpoint strongly supported by the literature (Greig 2002; Bean 2001). It is far from clear how many people, who present significant risks or have perpetrated actual harm to others, are treated under civil, rather than criminal, law, as again no statistics are recorded for

such circumstances. What research there is tends to focus on those subject to CPSA processes, so there is a clear gap here that should be filled.

Capacity

There has been wide debate, but limited agreement as to how capacity should be assessed (OPG 2011; Patrick 2009, 2008; Scottish Government 2008; Killeen et al 2004). Participants provided vivid examples demonstrating inappropriate use of persuasion, reflecting earlier debate about what constitutes informed consent or refusal to consent. Although the concept of 'capacity' has become central to care planning since the 2000 Act, there is less common agreement and understanding of this term than might be expected and many participants viewed assessing capacity as an important unmet training need.

Many participants identified failure to banish 'all or nothing' approaches to incapacity as problematic, though language reflecting such approaches continues to be used from time to time. Participants provided an example highlighting the earlier noted problem of differing terminology across the Acts, in this case over the meaning of incapacity, significant impairment and undue pressure, similar terms which all mean something slightly different. Police were reportedly reluctant to intervene in family situations under the 2007 Act unless the person at risk was personally making a complaint or lacked 'capacity' to do so. The 2007 Act refers to 'undue pressure', rather than 'incapacity' so this approach is erroneous in law. The consequent failure to investigate was reported to have left some adults at risk of exploitation or abuse from family members, in very similar circumstances to those which triggered the Borders Inquiry (SWSI 2004). This issue is worthy of further research as thus far commentators have made little reference to such issues.

Risk

Briefly returning to risk from an ethical perspective, participants suggested that intervention could actually increase risk, by alienating service users and their families and encouraging short cuts to care which undermine independence. The end result is snap decisions around capacity which exclude service users from involvement in decision-making. Furthermore, several participants identified collusion, whereby professionals tolerated informal carers administrating covert medication, using unsafe moving and handling practices or coercive approaches. Although viewed as largely well-intentioned means of avoiding admissions to care, these approaches, in the absence of sufficient formal support services, potentially compromise the rights of service users and the safety of carers and service users.

A further ethical issue about management of risk was identified related to the 2000 Act. Whilst the Act appears to give authority to intervene, in practice and according to some commentators (MWC 2012a; Patrick 2008), it provides no authority to 'enforce'. Although participants disagreed, views varied on how much control could be exerted in community settings. Most agreed scope for this was limited and that, paradoxically, the only way to enforce protective community care interventions, is in a locked establishment. Most participants regarded this as a major ethical concern, conflicting with the intention of the 2000 Act. Consequently, use of guardianship to underpin community living arrangements may be less common than expected.

Substance Misuse

As already noted, people misusing substances who could benefit from this legal framework appear to be facing discrimination from those responsible for diagnosis and assessment. Participants provided numerous examples, where it was clear that

Government aspirations to achieve an integrated approach to substance misuse and mental health are not being achieved. Misunderstanding, lack of cooperative working, outright hostility and discriminatory behaviour towards people with substance misuse problems were repeatedly identified. There is a fine line between whether it is mental disorder or substance misuse which impacts on judgement, and debate around which occurred first. This raises a much broader ethical issue, beyond the scope of this study, about the fact that the entire framework relies on the 2003 Act definition of mental disorder, which rules out intervention simply on the grounds of substance misuse. If the risk of harm due to mental disorder or physical infirmity is seen to be worthy of compulsory intervention, a few participants questioned why the same does not apply to substance misuse.

The evidence base

Many participants indicated that they did not believe the law is based on sound theoretical perspectives. Rather they believed that a combination of limited consultation, difficult cases, perceived public pressure and at times unjustified or uninformed criticism by regulators, led to continuing piecemeal attempts to modify law and policy in Scotland. Many participants regarded the principal regulator MWC as an ‘over-critical’ friend, largely ‘feared’ by local authorities. Reith (1998) asserted that changes to law or policy were often based on recommendations from case reviews, rather than wider reflection. However, this is not reflected in actual processes regarding core legislation. The 2000 and 2003 Acts were based on robust planning processes (SLC 1995, Scottish Executive 2001c). However, despite initial rigorous processes (SLC 1997), the 2007 Act was eventually implemented in response to the Borders Inquiry (SWSI 2004) resulting in a rather more piecemeal and reactive approach than planned (Patrick and Smith 2009). The McManus review

of the 2003 Act was based on routine consultation processes and quite limited research (Dawson et al 2009a; 2009b), but agreed changes were fairly minor (Scottish Government 2014). Proposals to reform the 2000 Act (SLC 2014; OPG 2011) remain in draft at the time of completing this study. Reforms to the legislative framework have otherwise been very limited, restricted to fairly minor amendments to the core legislation and the introduction of 13ZA, so perhaps participants' concerns about piecemeal reform related to local policy.

Principles and underpinning values

Commentators and codes of practice suggest that reflection on core principles can help practitioners deal with risk, explore complexities and reach decisions. (Keenan 2012). Participants did acknowledge some reflection on casework was based on the principles, which most viewed as a sound basis for the law, however, from a 'content analysis' perspective (Bryman 2008), dialogue across the groups focussed more on practice and legal issues. Interestingly several participants wrongly believed the principles had less legal standing than other parts of the legislation. A few participants suggested that despite references to 'benefit principles', these were often not acted upon. Such failure to comply with principles was viewed as an ethical problem by many participants. Principles relating to least restriction and skills development (s1 and 3, the 2000 Act) were thought to be undermined by local authorities' and regulators' interpretation of the duty to intervene. Participants believed using the law to mobilise community resources or prevent discharge from hospital, conflicted with reciprocity principles (Scottish Executive 2001c), relating to equal access to services, regardless of detention status (s1(g) of the 2003 Act). Several participants highlighted the important point that failure to detain when necessary compromised people's rights to treatment.

It appears that attempts to apply values to complex legal interventions through legal principles is challenging and many issues around ethics and the evidence base remain contradictory and unresolved. Nevertheless, participants and many commentators believed the legislative framework takes account of important developments in rights-based approaches and is grounded on a reasonably sound theory base.

5.2.3 Interpreting the law

The other key aim of this study was to understand how participants interpret the law. National data makes clear that there are substantial variations in the way that the law is applied across Scotland. No explanations have been advanced for these differences, so it was hoped that understanding what influences participants' interpretation of the law and examining accounts of day-to-day practice, would shed light on this. It was further intended that this might help identify potential amendments to the law or areas to be addressed in terms of training, organisational structure and process.

5.2.3.1 Using the law including any local variations.

Participants in this sample were taken from staff groups primarily involved in seeking measures across the legislative framework. There were however local variations in terms of responsibility. A brief overview follows of activity under each Act, citing local variations in process.

MHOs are legally required to produce reports in relation to guardianship applications, but at local level overall responsibility for taking applications forward varied. In Areas 1 and 3 MHOs took responsibility for applications, whilst in Area 2 applications were

led by case-holders. Participants across all areas largely supported the latter approach, valuing knowledge about the adult's circumstances above perceived knowledge of the law. Even before 13ZA, Area 1 managers actively discouraged staff from seeking guardianship to facilitate care admissions for compliant adults who lacked capacity to agree. This is difficult to justify legal or ethically, as the 2000 Act was intended to be the only means of taking significant welfare decisions on behalf of adults who lack capacity (MWC 2005; 2004). Otherwise processes were guided by operational instructions in Areas 1 and 2, whilst Area 3 apparently had no such instructions for any of the Acts. A few case examples were presented across all three areas highlighting major difficulties in managing covert or enforced medical interventions under the 2000 Act. There were conflicting perspectives on this between commentators, the regulator and the Codes of Practice. On this basis it appears intentions to clarify and simplify processes around decision-making on health issues remain aspirational (SLC 1997).

MHOs lead Compulsory Treatment Orders (CTOs) applications and NHS-approved psychiatrists lead all other 2003 Act applications, usually with MHO consent. National figures show that most CTO applications relate to hospital admission, many of which are later amended to community-based orders (MWC 2012b). The only local variation was in Area 3 where participants reported s47 of the 2000 Act being used, instead of CTOs, to detain older people in psychiatric hospital. Most participants echoed Patrick's (2008) unequivocal view, that the 2000 Act cannot authorise detention in hospital.

Participants reported that activity under the 2007 Act was led by a wider group of staff. Although a few banning orders were reported, most activity related to investigations and inquiries. Anecdotally Areas 1 and 3 reported greater use of these powers than Area 2, but there are no national statistics which can confirm this. Participants seemed very unclear about issues of accountability under the Act, but there was wide agreement that the 2007 Act was principally used as a gateway to the other two Acts, not as an end in itself.

Whilst MHOs exercise considerable autonomy in their statutory role under the 2000 and 2003 Acts, wider ranging autonomy of MHOs was seen to partly stem from managers not understanding the MHO role. This autonomy by default was viewed as unhelpful, undermining calls for consistent advice. Alternately, 'over-controlling' managerial approaches, particularly around the 2007 Act, were also viewed as unhelpful and likely to result in inconsistent decision-making. Several participants observed that management's wishes to satisfy other 'stakeholders' frequently resulted in pressure to do anything necessary to avoid criticism.

5.2.3.2 Principal sources of knowledge around the legal framework

Participants reported a wide range of means by which they acquired knowledge about the law, from formal training, written local and national guidance or through advice from others.

Training

Most participants reported a compartmentalised approach, whereby once training had been done on one Act, it was not readily available to new staff and training on later Acts was not fully integrated with previous training. Trainers disagreed on the latter point, but as providers of such training, bias might be expected. 2007 Act

training was provided in Area 2 prior to enactment and consequently lacked focus on actual practice. All areas reported some multi-agency training for the 2007 Act, but otherwise training on the Acts was 'in-house'. Participants perceived lack of training on risk within social work and other agencies as problematic, given the emphasis placed on risk within the framework, though Area 1 MHOs and a few participants in other areas reported improvements in that regard. Lack of training repeatedly featured in inquiries as a contributory factor to poor outcomes (MWC 2006b – 2016b; Reith 1998).

Written Guidance

My original contention that practitioners may be daunted by voluminous guidance is open to question. The 2007 Act, often perceived to be overused and widely misunderstood, contains the least guidance, so perhaps guidance for the other Acts, does enhance practitioners understanding. However, few participants reported directly referencing guidance and many regarded the whole framework as overly complex. Participants were concerned about increasing anomalies, such as the earlier noted enforcement of 2000 Act decisions and about perceived disagreement over fundamental elements of the framework at the highest level. Although the guidance has been subject to minor revisions (Scottish Government 2011c, 2010c, 2008a) and there have been some relatively minor amendments to the law, the main measures and processes remain unchanged, so these concerns remain relevant.

Advice

Two areas had appointed 'experts' (myself in Area 2) to advise and guide, a pattern reflected across the country (Ekosgen 2013). Findings from the current study (echoed in Ekosgen 2013) reveal that rather than accessing policy documents or the law itself, practitioners seek advice from local 'experts', from people they trust or

from more senior staff in the organisation, not from national bodies or ‘accredited’ experts. Participants believed local experts had formed their own, often differing, opinions about how the Acts should be implemented and these views were thought to wield significant influence on how practitioners use the framework, since they are often the authors, if not enforcers of local policy. When linked with the earlier noted ‘default autonomy’ managers grant to those perceived to have expertise, this provides possible reasons for variation in practice at local level.

It appears that appointing or encouraging staff to act in this role has helped local authorities interpret the substantial body of law, policy and guidance. Participants noted that senior managers, as much as practitioners and other agencies, were keen to utilise such expertise. However, it reflects a worrying lack of confidence at organisational level about the correct legislative route in any given situation. A few participants expressed concern about less formalised ‘pigeon-holing’ of individual expertise and experience. They believed this might lead to skills gaps and overuse of legislation where an ‘expert’ holds power (and strong views). The fact that MHOs lead guardianship applications in some areas and middle managers supervise guardians in Area 1 was cited as evidence that care managers are not trusted to manage complexities of legal processes. This seemed to underpin concerns over elitism expressed by some participants whereby care managers have less status than MHOs,

It seems likely that appointed experts have influenced use of legislation, leading to local variations across the country, a factor which should be considered in the context of any research into this phenomenon. However, given that the data

collection phase was several years ago, whether such experts still influence practice is unknown. However, it is very likely that senior MHO staff will continue to influence the direction of policy as described. Inter and intra-agency factors identified throughout this study and the influence of the Public Bodies (Joint Working) Act 2014, enacted in 2016, also merit closer examination.

Hierarchy of advice

Analysis of the data quickly revealed an informal hierarchical approach to seeking advice amongst practitioners. Initially advice was sought from those perceived to have knowledge, then from local experts (or MHO services), then local managers or legal sections (often regarded as unhelpful or obstructive) and finally to national bodies such as regulators. The final stage was often for confirmatory purposes. The MWC attracted strong criticism for providing contradictory or inaccurate advice, for refusing to provide advice and provoking fear. The MWC practice guides were generally welcomed, but regarded by a few as inaccessible.

A few participants commented that, useful as guidance was, it is the case-holder who has to 'operationalise' this advice. Several participants commented that they particularly valued input from their own managers, not so much in respect of the law but in managing practice dilemmas. This highlights what is perhaps an obvious point, that legislation is only one aspect of resolving practice issues, and that approaches such as 'structured clinical judgement' (Titterton (2005), also play an important part.

5.2.3.3 Factors which impact on the ability to use law

Participants identified a range of internal and external processes which influenced use of the framework and sometimes undermined effective decision-making. These included management approaches and application processes under the 2000 and

2007 Acts, in particular. Data collection systems were reported to be cumbersome and overly technical. Variable risk thresholds of others within and external to local authorities were regarded as problematic. Decision-making bodies and associated processes, including courts and tribunals, also impacted on use of the law. Most importantly however participants identified the role of gatekeepers, predominantly medical staff, as very influential.

Gatekeepers

Several participants were very concerned about the power of psychiatrists to detain indefinitely, perceptions which perhaps influenced the way they interacted with this group. A few participants regarded community options under the 2003 Act as the transplanting of hospital models to community care as discussed earlier (Rogers and Pilgrim 2001) and expressed concern about the dominance of medicalised approaches (Rogers and Pilgrim 2001; Wallcraft 1996). GPs were strongly criticised for failing to discharge their responsibilities under Part 5 of the 2000 Act or more generally towards the physical well-being of people with mental disorder (Scottish Executive 2006a).

As noted earlier, participants were frustrated by the behaviour of prosecutors, police and social work managers, as gatekeepers in criminal procedures and the 2007 Act. However, it was the gatekeeping role of medical professionals across the overall framework which many participants viewed as contradictory and a major source of conflict. The main contradiction identified, almost universally, was the question of who holds the power. None of the principal duties under the 2000 and 2003 Acts, for which local authority have responsibility, can be discharged without support from medical professionals, whose lack of co-operation in using the legislation was cited

repeatedly. Medical professionals were variously described as lacking commitment to core principles, lacking confidence in dealing with legislation and failing to properly consult others. Furthermore, many participants argued that medical staff do not understand the 2000 Act concept of capacity or the need to use appropriate legal measures to justify deprivation of liberty and restraint. Examples were led where participants believed doctors over-estimated the capacity of service users, thereby impeding the local authority's power to use appropriate protective legal measures. Fears were frequently expressed that service users, particularly older people, are likely to defer to medical professionals, leading to poor outcomes, such as unnecessary care admissions. Citing the relative power imbalance between medical and local authority staff, even professionals exercising local authority functions reported feeling 'browbeaten' at times and many were clear that their own management were unlikely to challenge this medical dominance. MHOs argued that their early involvement at case conferences, pushed strongly by the MWC (MWC 2008b), could have led to better consideration of alternatives and clear adherence to legal requirements. Whilst many participants emphasised that they enjoyed positive relationships with medical staff, they were very clear that local authorities were frequently prevented from discharging their duties because of these issues. Many participants expressed great concern that this was underpinned at a structural level, whereby the concentration of power in this legislative framework sits with medical professionals.

This undue concentration of power has been recognised by commentators and legislators and it has been suggested that other professionals should have a role in assessing capacity under the 2000 Act (SLC 2012; Killeen 2008, MWC 2008b).

However, this could only be achieved by changing the law, as in the Mental Capacity Act 2005, which allows a range of professionals to assess capacity.

Interagency issues

Despite the fact that failures in interagency working were identified in the planning documents which preceded all three Acts (Scottish Executive 2001c; SLC 1997, 1995), there is little in the legislation to enforce better working practices. The above noted problems with gatekeepers bring this into sharp focus, but reviewing inquires reveals longstanding problems over roles and disagreements about the need to use legislation (MWC 2006b – 2016b; SWSI 2004). Notwithstanding the pending Public Bodies (Joint Working) Act 2014, it has been left to policymakers to address interagency problems. Participants have reported improved relationships under 2007 Act processes, so perhaps this will provide a basis for improved cooperation.

Risk thresholds of others

Risk thresholds, much debated in the literature (Loxton, Shirran and Hothersall 2010; McLean et al 2008; Prins 1995), were linked with the need and justification for compulsory intervention (Atkinson et al 2007; Greig 2002; Bean 2001). Participants described a complex picture of differing risk thresholds across the wide range of professionals involved, though even amongst participants there were notable differences, more between individuals than professional groupings. Amongst participants most felt risks associated with self-neglect and deliberate self-harm were not taken sufficiently seriously by other professionals, but there was little agreement about responses to criminal behaviour and mental disorder. Participants regarded hospitals as risk-averse and police as non-interventionist particularly in relation to families, in-patients or to those in care. The Mr and Mrs D case (MWC 2012h) graphically illustrated problems for local authorities, when other agencies do not take

financial concerns in family situations seriously. Disagreements over referrers' risk assessments were a common source of conflict identified by participants. One inquiry (MWC, 2008b) came to light because of disagreement over risk between a housing association and the local authority. Conversely several participant identified cases where unreasonable expectations to manage risk had been placed on community-based services. These were a few of many examples where disagreements about risk potentially impacted on the ability of local authorities to intervene under the legislative framework.

Decision-making bodies

Participants made some comments about the conduct and expectations of tribunals, but the majority of participants' concerns related to sheriffs, who were reported to act independently and not always constructively. Sheriffs were often unwilling to accept MHO recommendations in relation to guardianship applications. In Area 1 sheriffs' incorrect judgement that the evidential criteria for banning orders should be at criminal rather than civil level, apparently led to reduced numbers of applications. Gordon (2004) had anticipated different views and knowledge around criteria for measures under the Acts could lead to inconsistency, later confirmed by the Ekosgen report (2013) which connected known views of sheriffs to local differences in decision-making.

5.2.3.4 Other factors which impact on use of the legal framework

MHO services were substantially reorganised in response to demands of the 2003 Act, and to some extent the 2000 Act. Additional resources allowed new structures to be put in place to support the 2007 Act. Participants were divided as to the benefits of 'full-time' MHO services, some very much in favour and others less so. However, no substantial research, since Maas-Lowit (2007), has been undertaken to establish

the effectiveness of these changes or to identify an ideal structure. This is an area that would benefit from further research.

Many participants referred to challenges using this legislation for people who did not fit into commonly identified user groups. These included people with multiple sclerosis, Huntington's disease, acquired brain injury and people on the autistic spectrum. Lack of specialist resources, including dedicated psychiatrists, meant that intervening with these groups posed particular problems. The level of legal and medical expertise necessary to understand the complex interplay between definitions of mental disorder, incapacity and the criteria for intervention often seemed to be lacking. A few participants expressed concerned that the legislation was sometimes used to impose restrictions on people in the absence of adequate resources to support and promote independence. It did appear that with persistence, the 2000 Act in particular, had been used effectively in many such cases.

Many participants asserted that legal aid regulations (Assistance by way of Representation Regulations 2003) promote inconsistent use of the 2000 Act. Applications for financial guardianship sometimes include welfare, simply to benefit from legal aid and unnecessary financial applications may be tied in with (free) welfare applications as a contingency measure. MHOs criticised MWC reports (for example MWC 2012h) which they perceived unreasonably blamed them for failing to challenge financial exploitation, indefinite guardianship applications or use of so-called 'plenary' powers (Ward 2004) all of which conflict with the least restrictive principle (s1(3) the 2000 Act). MHOs across all areas described strenuous efforts to

persuade sheriffs to strike out unnecessary powers or limit the timescales, largely without success.

It was evident that participants, managers, legislators and regulators regard many aspects of the legal framework as resource intensive. Efforts to undermine and dilute the 2000 Act since its inception were outlined in the review of literature, particularly attempts to reduce use of guardianship and rapid amendment of Part 5 of the Act (Patrick 2008; MWC 2007d, 2005; 2004; Davidson et al 2004; Killeen et al 2004). It is clear that participants have received this message, the unfortunate consequence of which is that many reported being more hesitant to use the 2000 Act as a result.

5.2.4. Concluding thoughts

At the risk of oversimplifying matters the principal conclusions are very briefly summarised before moving on to the recommendations, although it is worth briefly rehearsing my own preconceptions before proceeding. I believed the legislation was potentially overly bureaucratic and that guardianship in particular was being undermined by perceptions about resource demands. Furthermore, I believed that factors which undermined the law occurred across the professional spectrum not just psychiatry. In these areas my beliefs were broadly supported. However, I did not find evidence that community based CTOs were overused, nor did I find an answer as to whether the law was used inconsistently or simply ‘flexibly’. It was unclear how far the law help practitioners to manage risk and there was a mixed picture in terms of how well professionals exercising local authority functions understood the law.

From participants’ perspective the framework was broadly seen as credible and based on sound principles. Recognition of the valuable role of relatives,

individualised approaches to assessing capacity, broad coherence across the three Acts all contributed to this view, however there were several areas of concern. The potential for relatives to abuse power was not felt to be balanced by processes which allowed authorities to intervene effectively. The law was at times used to compel people to accept care or other interventions which might have been un-necessary, if adequate resources were available. Concern was expressed that hospital based processes had been imposed on communities. Participants were unclear as to whether an appropriate balance was achieved between accepting lifestyle choices and managing illness driven behaviours, particularly in relation to substance misuse and offending behaviour. Furthermore, participants believed that unethical and inconsistent approaches to diagnosis, assessing capacity and culpability impacted on the credibility of the framework. The introduction of 13ZA undermined an otherwise coherent ethical approach to incapacity. Concerns were expressed that the legislation set unrealistic goals in terms of risk management and that this was tied in with an increasing blame culture at government level.

Interpretation of the law seemed consistent across the areas in many respects, but it became clear that sources of advice and guidance had a significant impact on how different elements of the law were viewed. It was agreed that lack of urgent measures was a problem across the framework, whilst the main differences related to 13ZA, MDOs and use of compulsion under the 2003 Act. Participants reported that their ability to intervene was impeded by bureaucratic processes, limited resources and most importantly, actions of gatekeepers, in particular medical staff. Finally, differing thresholds for risk impacted on local use of the law.

One of the greatest overall concerns for participants related to attempts to circumvent legal processes from individual to government level, which it was believed undermined the sound ethical intentions of the legal framework and contributed to the wide variation in use of the framework across areas.

5.3 RECOMMENDATIONS

Recommendations are grouped under three broad headings for ease of reference, namely research, practice and legislation and brief justification is provided in each case.

5.3.1 Research

5.3.1.1 Responding to Mentally Disordered Offenders

Participants identified failure to prosecute offenders; failure to support vulnerable perpetrators and lack of knowledge about processes even among MHOs. Given that a central aim of reforming the 1984 Act was to address the high incidence of mental disorder amongst offenders, there is surprisingly little research which examines the success of revisions to the 2003 Act and CPSA in meeting the needs of mentally disordered individuals who commit offences, or for that matter the needs of society. Additionally, this study reveals that many people are diverted from prosecution and again there is no research which quantifies this or examines the reasons why. It is therefore proposed that research should be undertaken to address all these areas, Furthermore, when the MOP was revised in 2010 (Scottish Government 2010e) a training strategy to raise awareness of the 2003 Act measures and to address risk was established by Government. Reviewing the ongoing success of this approach could usefully be included in such research.

5.3.1.2 Inappropriate and inconsistent use of legislation

This study revealed wide variation in use of legislation, for example s47 of the 2000 Act was used to detain people in hospital: a practice which most participants believed was inappropriate. Use of 13ZA and guardianship also varied considerably between the three areas studied. It was also clear that informal measures were being used where legislation was more appropriate, for example ‘de facto’ detention of people in hospitals or care homes. Research should be undertaken to try and understand the extent of these alternative uses of legal powers. It is recognised that trying to recruit participants who will be willing to talk about use of legislation which is either illegal or inappropriate would be challenging.

5.3.1.3 Issues of risk

Risk assessment across the legislative framework was an issue which caused concern for participants. Whilst there was broad agreement about risks in the case studies throughout the groups, there were very diverse views on approaches to assessing and managing risk. There was also some confusion over the terminology used to describe risk across the legislative framework. Furthermore, it was suggested that risk-averse attitudes prevent people from receiving appropriate treatment, when it would be most beneficial. It is unclear how far these diverse views about risk influence differential use of the legislative framework, but a few participants certainly made that connection. There is clearly a considerable literature base around risk, however, not in relation to this legislative framework. Research into definitions, attitudes and thresholds for risk might contribute to improving practice and consistency of approach in managing risk, in the context of this legislative framework.

5.3.1.4 Statistical data and monitoring of activity

In undertaking preparatory work for this study, and from participants' accounts, it is clear that statistical information about several aspects of the framework is unavailable, particularly in relation to the 2007 Act and Part 5 of the 2000 Act. Whilst there are proposals to improve administration of advance statements (Scottish Government 2012c) no similar commitment to named person arrangements has been proposed. Additionally, despite the Government's commitment to monitor the impact of 13ZA (Scottish Government 2008a), nothing has been put in place. Given that no explanation can be offered for widespread variation in use of the law (MWC 2014k), establishing a comprehensive monitoring strategy should be prioritised.

5.3.1.5 Guidance

This study suggests that expertise has become pigeon-holed, such that appointed 'experts' and MHOs take considerable responsibility for advising and guiding local authority staff on this complex legal framework. This may contribute to differential application of the law across different areas. Research should be undertaken to establish sources of knowledge utilised by health and social care staff with a view to developing a more consistent approach to providing guidance across agencies and geographical areas.

5.3.1.6 Multi-agency issues

Since the NHS and Community Care Act 1990, nurses and OTs have been employed by social work to carry out social work functions. There are also many teams which combine NHS and local authority employed staff to deliver on community care objectives. Participants in the one authority in this study where these groups were represented were critical of the failure to support the engagement of NHS staff in utilising this legislation. The Public Bodies (Joint Working) (Scotland) Act 2014 promotes delegation of functions between health and social work agencies,

yet there is little evidence, so far of any strategic approach to integrated functions relating to this suite of legislation. Research should be undertaken into how local authority duties in relation to this framework are currently being discharged in integrated services, to identify any gaps and recommendations for improvement.

5.3.1.6 360º view

Wider perspectives of users, carers, medical staff, police, lawyers and voluntary organisations were acknowledged to be a gap in this research. Although the focus of this research has been on local authority duties, understanding these wider perspectives could help shed light on differential use of the framework and whether there is common understanding about measures contained within the individual Acts. Many participants identified lack of shared understanding as a major problem in inter-agency relationships when attempting to use the legislative framework.

5.3.1.7 Service structure

The varied structure of MHO services across Scotland, driven by the legislative framework was apparent, even just in three local authority areas. Although research was undertaken to examine differing MHO service structures (Maas-Lowit 2007), this has not been followed up. It would be valuable to re-visit this research and establish current perspectives on service structures in the light of the 2007 Act and recent moves to integrate health and social care services. Further to this one recent study revealed that a third of the MHO workforce are likely to retire in the following five years (SSSC 2014) so opportunities to understand any challenges for recruitment would be valuable, given the importance of maintaining sufficient numbers of MHOs.

Another aspect of service structure which emerged was the compartmentalised approach in using the framework for particular disciplines, for example the 2000 Act

was predominantly used in older people and learning disability services and the 2003 Act in CMHTs. It would be valuable to understand firstly if this is more broadly reflected across Scotland and if so whether this is a training issue, a limitation of the Acts or indeed if it is not perceived to be a problem.

5.3.2 Recommendations for Practice

5.3.2.1 Training

Based on participants' views and conclusions of this study, it is recommended that where training is provided, it should incorporate all three elements of the framework, have a multi-agency component and enable staff to access human or written resources which can assist. Focus group participants were very positive about the format of discussion within these groups, based on case studies and more generalised discussion about the whole framework, and believed this would be a good model for future training.

5.3.2.2 Roles

Roles were deployed slightly differently across the three areas and a few care managers believed MHOs behaved in an elitist manner. Of the three roles identified in legislation, namely council officer, social work officer (SWO) and MHO only the MHO training is accredited by the SSSC. Whilst Council Officer training is well developed in some areas, SSSC accreditation might be beneficial in raising standards across the country. The role of SWO under the 2000 Act was not even mentioned by participants and receives little attention in the literature, yet according to the code of practice (Scottish Government 2008a), the SWO leads applications for guardianship, supervises guardians and undertakes investigations. Training for those carrying out the role of SWO might improve the status of care managers and

guidance on the interface between all three of these roles might bring some consistency across areas.

5.3.2.3 Blame Culture

An emerging blame culture, exacerbated by the 2007 Act, was identified in literature (Ekosgen 2013; MacKay et al 2011) and by several participants. For many this was further reinforced by an over-critical approach from the MWC. It was perceived that Government, regulators and senior management, believe that now the legislative tools are in place, responsibility for failures in community care arrangements lies with practitioners. Whilst there is no obvious recommendation to address this issue it should be considered when undertaking investigations and inquiries, otherwise the potential for growth and development in using the law could be compromised by fear of censure.

5.3.3 Recommendations for Legislation and policy reform

Participants in this study tended to view the legislation more in terms of its component parts rather than as an overall framework. Use of different terminology to describe similar things was identified by participants, for example incapacity, undue pressure and significantly impaired decision-making. These terms were sometimes viewed as interchangeable, yet there are subtle differences in meaning between these terms. This also applies to principles, which are stated quite differently under each Act. This may have arisen because the Acts were implemented at different times and drafted by different groups of professionals. There would be benefit in reviewing the three Acts to harmonise terminology and the measures where possible. The interface between the 2000 Act and SDS 2013 should also be examined as there were concerns over undue concentration of power where welfare guardians are appointed as proxies under the 2000 Act.

5.3.3.1 Principles

Consideration should be given to whether the principles continue to be fit for purpose, for example there are no principles relating to public protection and participants believed principles such as ‘benefit’ lacked commitment. It was not clear whether participants understood that principles had the same legal standing as other parts of the legislation, so consideration might be given to emphasising this in revised guidance or in training strategies.

5.3.3.2 2000 Act

There have been many minor amendments to this Act, but widespread debate about guardianship has led to confusion about Government expectations. Participants and literature accessed for this study makes clear that piecemeal, reactive change to legislation should be resisted. The areas most in need of review are guardianship, assessment of capacity and deprivation of liberty, whilst related measures under 13ZA are increasingly seen as inadequate (Ward 2007; Scottish Courts 2007, 2004). Although the SLC proposals (SLC 2014) go some way to addressing these issues, the OPG proposals for graded guardianship (OPG 2011) provide a more straightforward starting point.

Participants presented numerous cases where medical gatekeepers obstructed what they believed to be valid use of the 2000 Act and there were many examples where decisions about capacity were made on the basis of expediency rather than on objective criteria. Patrick (2008) raised wide-ranging concerns that the current Act was not compliant with human rights legislation and did not adequately address issues of deprivation of liberty. It would certainly be possible to broaden the groups of professionals involved in assessing capacity, in a similar way to the Mental Capacity Act 2005. The role of the MHO could also be enhanced. This might go

some way to addressing problems with medical gatekeepers and compliance with human rights legislation.

5.3.3.3 2003 and 2007 Acts

Reform of the 2003 Act is ongoing at the time of writing, so these revisions should be given a chance to take effect before further reform is considered. The 2007 Act is clearly flawed, at least in terms of enforcing measures, as is clear from both literature and this study. However, the Act is primarily used to investigate circumstances where an adult is at risk. From the perspective of participants and to some extent the literature (MacKay et al 2011) the problem with investigation relates more to interpretation than to the statute itself. It is difficult to identify any beneficial changes which might be made to this Act at this time. However, should improved data collection on use of the 2007 Act be forthcoming, areas for improvement might become apparent.

5.3.3.4 Substance misuse

Despite two major government policy initiatives to improve integrated working (Scottish Government 2007; Scottish Executive 2003), problems continue to be reported. Participants and inquiries (for example MWC 2012e; 2006b)) repeatedly highlight the links between problematic substance misuse and the occurrence or recurrence of mental health problems, which require intervention under this framework. Participants described ongoing disputes between service providers about lead responsibility in dual-diagnosis cases and the need to ensure better co-ordination between the services, echoing findings in a recent MWC report (MWC 2013c). This policy area should be revisited with a view to identifying how these issues can be addressed more effectively.

5.3.3.5 Bodies engaged in legal reform

Bodies such as the MWC, SLC and OPG wield considerable influence when reforms to this legislative framework are being considered. Given that the MWC and OPG deploy considerable resources to monitor and support the 2000 and 2003 Acts, their support for recommendations which dilute measures, risk accusations of conflict of interest. Participants and researchers were also critical of legalistic aspects of the framework and the role of lawyers, so the prominence given to the SLC might also be questioned, especially given the complex nature of their recent proposals for reform of the 2000 Act (SLC 2014). Although proposed legal changes are usually subject to widespread consultation, respondent to these consultations rarely include individual practitioners (Scottish Government 2013a, 2012b). Participants certainly did not feel they had opportunities to contribute to developing this legislative framework and viewed reform processes as reactive and politically driven. It is therefore recommended that more transparent and inclusive approaches to reform should be considered.

5.4 CONCLUDING THOUGHTS

In conclusion this research demonstrates significant progress in developing a coherent legislative framework in Scotland. Whilst there were mixed views amongst participants about process issues, there was clear support for the perceived intentions of the framework to support individual rights to receive appropriate care, treatment and protection in the least restrictive manner possible. There are undoubtedly mixed interpretations and misunderstandings about the meaning of the law, some of which could be seen as providing desirable flexibility. It is however, clear that work is needed on the 2000 Act, and perhaps measures under the other

Acts, to address anomalies and bureaucratic obstacles and to clarify intentions. There is undoubtedly a significant body of expertise in this legal framework across Scotland and the vast majority of participants have demonstrated a will to try and make this framework successful at practitioner level, which should be seen as positive sign for future developments. In considering further reform to the Acts and related policy I would urge policy makers to remember that there is a considerable body of expertise in this group of practitioners and that it would be beneficial to ensure their views are sought in relation to any planned reforms.

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Appendices

Appendix 1: Letter to local authorities

Iain Fisk

iainfisk@yahoo.co.uk

Director of Social Work
….. Council
…….

Dear ……

Research Access Request – Adult Protection Legislation

I am currently undertaking an M Phil with the School of Education, Social Work and Community Education at Dundee University. My tutor is Dr Murray Simpson and he would be happy for you to contact him directly if necessary. I am undertaking this on a part-time basis as I have a full-time post, currently Acting Service Manager within ….. Social Work and Health. My employment for the last 7 years has been primarily concerned with oversight of the Mental Health Officer service and planning issues in relation to adult protection legislation, though I also currently oversee Substance Misuse services and Homeless Housing Support. I am also a General Member on the Mental Health Tribunal for Scotland. The piece of research I am undertaking forms the entire basis of my M Phil and is therefore a substantial piece of work, which I would expect to complete within the next two to three years. The theme for this research is based around the following research question.

"Does the legislative framework (Adults with Incapacity (Scotland) Act 2000, Mental Health (Care and Treatment) (Scotland) Act 2003, Adult Support and Protection (Scotland) Act 2007), put in place since the inception of the Scottish Parliament, help or hinder in the protection of vulnerable adults?"

I have an abiding interest in adult protection legislation and have often debated issues with colleagues from other local authorities, the Mental Welfare Commission and government officers. I have discussed this research with many of these individuals and there is strong interest in the outcome. I am particularly interested in how this legislation impacts on attitudes to risk for individual officers and for management in local authority. I very much hope that in undertaking this research I will be able to raise both concerns and positive issues within the government, which may in turn lead to clarification or simplification of procedures, which to my mind do seem overly complex and at times bureaucratic. This is however, my hypothesis and it may be that this research shows greater satisfaction with the legislative framework than I would expect. Whatever the findings, I hope this research will enhance the

debate on adult protection and help to achieve better care and protection for adults at risk of harm and perhaps most importantly will help clarify some of the issues for local authority staff who have to work with this legislation on a day to day basis.

In undertaking this research I wish to interview individual staff members, involved in managing services, and conduct a maximum of three focus groups involving ground-level professionally qualified staff from care management and MHO services. It is possible, though unlikely, that I might follow this up with a questionnaire to the same groups of staff to clarify issues which have not been fully covered in the course of these processes. The focus of this research is on the perspective of those charged with managing the legislation, so it is not my intention to directly seek the views of service users, though I hope to reflect user perspectives through use of publicly available research and writing. It is envisaged that the interviews and groups will take place from March to July next year. I enclose a rough outline of the questions I intend to ask and activities I will undertake within focus groups. Clearly I would not expect staff to be in any way coerced to participate in this process, but I do hope they will feel this to be a worthwhile piece of research and will wish to be involved. I would like to tape record these interviews to ensure I miss none of the data that is collected. This will be important because I do not intend to involve research assistants and will undertake all interviews and groups myself. Staff responses would of course be confidential and all identifying features in relation to individuals would be removed. All work undertaken with respect to this research will be subject to the approval of the university Ethics Committee.

I have chosen to cover three local authority areas which I think will provide a cross section of the Scottish situation. I am aware that these three areas have quite different approaches at least to guardianship and adult support and protection and will be interested to see if there are greater similarities in use of mental health law. Apart from data collected from staff members I will also be seeking some statistical information about local usage of the Acts. I would also find it helpful to access documents in your authority which relate to this legislation, whether operational guidance or policy statements. It is in no way my intention to identify or dwell on any ‘shortcomings’ of the local authority areas under scrutiny rather to identify areas of convergence and areas of difference and overall to pick up an idea from different areas how this legislation is viewed and whether indeed it is regarded as helpful or is confusing for staff. In fact I would expect the vast majority of identifiable information used to already be in the public domain and will quote staff members very selectively to avoid any ‘comeback’ on staff members or the authority as a whole.

I would also be happy to send early drafts of the parts which relate directly to your authority before publication to ensure there are no significant inaccuracies and to offer the opportunity to discuss any concerns for you arising from the publication of this information.

I will certainly be happy to credit your local authority’s participation in the research, unless you would rather remain entirely anonymous in this thesis, and would be very happy to share the findings with any groups of staff within your authority who might have an interest.

I would be grateful if you could let me know if you would be willing to participate in this research and identify a person within your organisation with whom I should communicate further. I will be very happy to discuss this further with yourself or your nominated representative.

I look forward to hearing from you.

Yours sincerely

Iain Fisk
Cc Dr Murray Simpson, School of Education, Social Work and Community Education, University of Dundee, Nethergate, Dundee DD1 4HN

Appendix 2: Participant Information Sheet

PARTICIPANT INFORMATION SHEET
TITLE OF PROJECT
Does the legislative framework since the inception of the Scottish Parliament help or hinder in the protection of vulnerable adults

INVITATION TO TAKE PART IN A RESEARCH STUDY
You are being asked to take part in a research study, which is looking at the interplay between the different pieces of adult protection legislation in Scotland. I am undertaking a Master of Philosophy in research, through Dundee University School of Social Work, Education and Community Education and am being supervised by Dr Murray Simpson a lecturer in the Social Work Department. I am employed by ….. Council Social Work, working in a post which spans operations and strategic planning and is primarily concerned with adult protection legislation and oversight of the Mental Health Officer service. Whilst this research is clearly closely related to my work the research is being conducted entirely independently from my employment except for the fact that I am given some time off and some assistance with funding.

PURPOSE OF THE RESEARCH STUDY
This study aims to look at the implementation of three Acts across Scotland (Adults with Incapacity (Scotland) Act 2000, Mental Health (Care and Treatment) (Scotland) Act 2003, Adult Support and Protection (Scotland) Act 2007) and seeks views from social work practitioners as to the effectiveness of the legislation, with particular reference to how the Acts complement each other, or perhaps throw up contradictions. Of particular interest is the notion that the legislation seems to be being used differently in different locations and clarity is sought as to why this might be – or indeed if there are greater similarities in usage than is apparent. Additionally of interest is the extent to which the volume of legislation, guidance and regulations enhances practitioners' ability to respond or reduces flexibility of response. Overall as the title of the research suggests the study seeks to establish whether the fact that these three pieces of legislation often cross over, leads to confusion on the part of practitioners as to which piece of legislation may be appropriate at any given time or if this 'menu' of interventions is considered to be helpful and coherent.

The findings of this research will be used to identify links, overlaps and shortfalls in the legislation and guidance and to make recommendations at a local policy level and at governmental level in terms of the need for legislative change.

Participation in this research would therefore benefit social work practitioners who are involved in decision making and care of vulnerable groups in that it aims to clarify issues and perhaps to produce or at least influence legislative change. Clearly if 'the system' works better, users of services and those subject to the Acts will also benefit.

TIME COMMITMENT
The study will require to be completed within the next two years. A significant part of the research paper pulls together existing commentary on the Acts and relevant

literature. However, the 'live' data collection part involving interviews, focus groups, and possibly questionnaires, will take place between March and September 2009. It is not intended therefore that participants will have any ongoing contact in relation to this research, rather that their input will be through one individual interview or participation in one or two focus groups. There may be a need for a follow up interview for clarification purposes.

TERMINATION OF PARTICIPATION

Participation in this research project is entirely voluntary and you may decide to stop being a part of the research study at any time without explanation. There will be no consequences in relation to your employer for whom it has been made absolutely clear that there is no obligation to participate and that there should be no consequences for individuals who withdraw from interviews or focus groups whatever the reason.

RISKS

There are no known risks for you in this study, and there is no reason to suppose that any issues causing distress will arise. However, if you find the topics of discussion upsetting for any reason I am very happy to provide private time to discuss any issues and to refer back to your employer for assistance in identifying any longer term support that may be required if that is your wish. Clearly if in the course of discussion you disclose information which will place an adult or child at risk it may be necessary for me to take this information to your employer. I would, apart from in the most exceptional of circumstances, always indicate to you that I intend to do this. Again this would be a highly unlikely outcome of your involvement in this study as the topics raised will be familiar to you in your everyday work and focused on your roles therein and are not seeking to uncover issues of bad practice.

COST, REIMBURSEMENT AND COMPENSATION

Your participation in this study is voluntary. No fee will be payable as your employer has agreed to your participation in this research during working hours and you will be able to claim appropriate travel and subsistence expenses from your employer in the usual way.

CONFIDENTIALITY/ANONYMITY

The data collected will not contain any personal information about you, except in terms of describing your professional role and possibly the local authority for whom you work.

No one will link the data you provided to your identity and name. This data will be held securely in a locked cabinet in the researcher's office base or on computer files which are passworded and will only be accessible to the researcher. Your employer will be given an initial draft of the thesis which will give an opportunity to comment on points of accuracy. There is no obstacle to this being shared with you. With regard to the final thesis, parts or all of the research may be published in relevant journals or elsewhere and will be submitted to your employer and to government along with any recommendations arising in relation to policy matters or proposals for legislative change.

FOR FURTHER INFORMATION ABOUT THIS RESEARCH STUDY

Iain Fisk will be glad to answer your questions about this study at any time. If you want to find out about the final results of this study, you should contact him directly at ……

The University Research Ethics Committee of the University of Dundee has reviewed and approved this research study.

Appendix 3: Consent Form

INFORMED CONSENT FORM

TITLE OF PROJECT Does the legislative framework since the inception of the Scottish Parliament help or hinder in the protection of vulnerable adults

This study aims to look at the implementation of three Acts across Scotland (Adults with Incapacity (Scotland) Act 2000, Mental Health (Care and Treatment) (Scotland) Act 2003, Adult Support and Protection (Scotland) Act 2007) and seeks views from social work practitioners as to the effectiveness of the legislation, with particular reference to how the Acts complement each other, or perhaps throw up contradictions. Of particular interest is the notion that the legislation seems to be being used differently in different locations and clarity is sought as to why this might be – or indeed if there are greater similarities in usage than is apparent. Additionally of interest is the extent to which the volume of legislation, guidance and regulations enhances practitioners' ability to respond or reduces flexibility of response. Overall as the title of the research suggests the study seeks to establish whether the fact that these three pieces of legislation often cross over, leads to confusion on the part of practitioners as to which piece of legislation may be appropriate at any given time or if this 'menu' of interventions is considered to be helpful and coherent.

By signing below you are agreeing that you have read and understood the Participant Information Sheet and that you agree to take part in this research study.

_____ _____ _____

Printed name of Participant Participant's signature Date

_____

_____

Printed name of person obtaining consent Signature of person obtaining consent

NOTE: The Consent Form should normally be separate from the Participant Information Sheet so that the participant has something they can keep.

UREC v. 1.9, 15 December 2006

Appendix 4: Case Studies

Case study 1
Victor has moderate to advanced dementia and has been at increasing risk as a result. Although he had some fixed routines such as a Tuesday evening at the local pub with an old friend, Jack, he became increasingly confused and disorientated whilst living in his sheltered house. He was increasingly found wandering, looking for his long dead mother at times. He was always a very smartly dressed man, but this had also slipped badly. He has been throwing out possessions, even food and clothing, claiming that it is all being stolen by people accessing his flat while he is out. Jack had often helped to keep Victor out of trouble as his behaviour became increasingly erratic. Eventually he was persuaded to go into hospital for assessment. If asked he says he doesn't want to be there but he is not actively trying to leave. Jack has visited him almost every day to try and help him get used to it. All agree he can no longer look after himself and that he requires admission to nursing home care but Victor does not seem able to understand what is being proposed. He says he doesn't need to go somewhere that he will have to stay in bed every day.

One of his sons holds a continuing power of attorney over him and has frequent contact. He has had to exercise this power for sometime. He has been quite dismissive of attempts to keep his father at home and strongly disapproves of alcohol. His daughter takes a more sympathetic view of her father, but cannot see him as often as she often travels abroad with her work

Questions
Please take a few moments on your own to identify risks and write them down here

Please take a few moments to think about these issues and take some notes here before discussion in the full group

1. Is there any application of the MH Act now or later you think is relevant

2. Is there any relevance to AWI now or later

3. If not AWI is there any other legislation

4. If a guardianship were to be sought who should apply

5. What facilitates use/what hinders use?

6. What are benefits/drawback of use of legislation in the case

Case study 2

Harvey is an adult with a moderate to severe learning disability. Now 40 he has been cared for by his parents who are now ageing and frail. They live in a large rambling house which they own. Although Harvey is quite disabled by his condition the parents have an interdependent relationship with him as he is their only child. He has to take anti-epileptic medication which he does not like, so his parents crush the tablets into his porridge. They are uninclined to let him go to the local day centre as they feel he would be subject to bad influences there, although the care team believe he could gain much from an independent living skills programme at the centre. Although resistant to attending the day centre, due mainly to his parents influence, he is keen to try living in a local housing project which provides some tenancy support. Although he has some ability to deal with day to day money, he is susceptible to exploitation and there have been some problems with 'friends' borrowing money or selling him useless items at inflated prices. These friends are known locally and are suspected of targeting other vulnerable people. Harvey has also recently inherited £15.000 from a doting aunt who passed away recently.

Questions

Please take a few moments on your own to identify risks and write them down here

Please take a few moments to think about these issues and take some notes here before discussion in the full group

1. Is there any application of the MH Act now or later you think is relevant

2. Is there any relevance to AWI now or later

3. Is there any relevance to ASPA now or later

4. If not these is there any other legislation

5. If a guardianship were to be sought who should apply

6. What facilitates use/what hinders use?

7. What are benefits/drawback of use of legislation in the case

Case study 3

Drew has bi-polar affective disorder and at times behaves in a threatening manner towards support staff who visit him at home. He recently sent a dead bird to one, with a note saying – 'your next'. He has been arrested on several occasions for breaches of the peace and possession of knives. He has never actually carried through any threat towards anyone and so far no charges have been pursued on the grounds that he has a mental disorder and that this would be counterproductive. He is well known by local police who see him as something of a 'poor soul' who doesn't get the support he needs. Most of these aggressive incidents seem to occur when he is on a 'high' – which is sometimes thought to be illness related and at others to relate to drink or illicit drugs. When on a 'low' he withdraws refusing to see workers. Neighbours have complained lately about noise at night and his use of verbal abuse to them at times. Some staff believe he does not see the consequences of his 'wrongdoing' and that he should be punished as anyone else would. Others see this as too punitive and would like to see him brought into some kind of care establishment or even hospital to give him consistent treatment. The fiscal is seeking a psychiatric report about the latest incident.

Questions

Please take a few moments on your own to identify risks and write them down here

Please take a few moments to think about these issues and take some notes here before discussion in the full group

1. Is there any application of the MH Act now or later you think is relevant

2. Do you think criminal proceedings should be pursued, even if in the context of the MH Act e.g. compulsion order etc

3. Is there any relevance to AWI now or later

4. Is there any relevance to ASPA now or later

5. If not these is there any other legislation

6. What facilitates use/what hinders use?

7. What are benefits/drawback of use of legislation in the case

Appendix 5: Participant Characteristics

No.	Qualification	Role	User group	Gender
1	MHO/Social worker	MHO Team member	All adult	M
2	MHO/Social worker	MHO Team member	All adult	M
3	MHO/Social worker	Hospital based Social worker	Palliative care	F
4	MHO/Social worker	Social worker/Care Manager	LD/Older people	F
5	MHO/Social worker	Social work Out of Hours team	All adult	F
6	MHO/Social worker	Criminal Justice Team Manager	Criminal Justice Service	F
7	Social worker	Community care team	All adult	M
8	MHO/Social worker	Team manager MHO Team	All adult	F
9	Social worker	Adult Protection Officer	Training/development	F
10	MHO/Social worker	Team manager MHO team	All adult	M
11	Social worker	Response team	All adult	M
12	Social worker	Hospital based Social Work	Adult Mental Health	F
13	Social worker	Intake/Learning disability	Learning disability + adult	M
14	Social worker	Planning Commissioning Officer	Development/Training/ Learning disability	F
15	Social worker	Response team	All adult	M
16	Social worker	Development Officer	Development/training MH	M
17	MHO/Social worker	Team manager review team	All adult	F
18	MHO/Social worker	Team manager Older People team	Older people	F
19	MHO/Social worker	Care manager	Older people	F
20	MHO/Social worker	Care manager	Learning disability	F
21	MHO/Social worker	MHO team member	All adult	F
22	General Nurse	Care manager	Physical Disability	F
23	General Nurse	Care manager	Older people	F
24	Social worker	Care manager	Older people	F
25	MHO/Social worker	MHO team member	All adult	F
26	Community Psychiatric Nurse	Case manager	Adult Mental Health	F
27	MHO/Social worker	Care manager	Older people	M
28	Social worker	Care manager	Older people	F

29	Community Psychiatric Nurse	Care manager	Older people	F
30	MHO/Social worker	Case manager	Adult Mental Health	F
31	General Nurse	Care manager	Older people	F
32	General Nurse	Care manager	Older people	F
33	Community Learning Disability Nurse	Care manager	Learning disability	F
34	Community Learning Disability Nurse	Care manager	Learning disability	F
35	Community Psychiatric Nurse	Case manager	Adult Mental Health	F
36	Community Psychiatric Nurse	Case manager	Adult Mental Health	M
37	Social worker	Case manager	Adult Mental Health	F
38	Community Psychiatric Nurse	Case manager	Adult Mental Health	F
39	Social worker	Care manager	Older people	F
40	MHO/Social worker	MHO Team manager	Adult Mental Health /Forensic	F
41	MHO/Social worker	Social worker	Adult Mental Health	M
42	MHO/Social worker	Social worker	Learning disability	F
43	MHO/Social worker	Social worker	Older people	F
44	MHO/Social worker	Social worker	Adult Mental Health	M
45	MHO/Social worker	Training officer	Training/development	M
46	MHO/Social worker	Training officer	Training/development	F
47	Social worker	Social worker	Access team	F
48	Social worker	Care manager	Adult care	F

BREAKDOWN ACCORDING TO CATEGORIES				
Qualification				
	Area 1	**Area 2**	**Area 3**	**Total**
MHO (all social work qualified)	8	8	7	23
Social worker	8	4	2	14
Nurse CPN		5		5
Nurse General		4		4
Nurse CLDN		2		2
Totals	16	23	9	48
Role				
Care manager	2	19	1	22
Social worker	8	2	5	15
Promoted posts				
Training/development officer	2		2	4
Team manager	3	2	1	6
Adult protection officer	1			1
Gender				
Male	8	2	3	13
Female	8	21	6	35
User group (NB some workers specified more than one user group				
Learning disability	3	3	1	7
Older people	8	10	1	19
Adult Mental Health		6	3	9
All adult	9	3	2	14
Palliative care	1			1
Physical disability		1		1
Criminal Justice Service	1		1	2
NHS employed				
Nurses		7		7

Appendix 6: Search terms and databases

Search terms used in this study:		Databases
Abuse Adult protection Adult support and protection Anti-psychotic drugs Capacity Care settings Care Care settings Capax Community care Disability Home care Incapacity Incapax Incapacity law Insanity Institutional care Institutionalisation Intellectual disability	Mental disorder Mental handicap Mental health Mental health law Mental health officer Mental Illness Mental well being Learning difficulty Learning Disability Nutrition . Psychiatry Psychosis Risk Recovery Sanity Social inclusion Supported accommodation Sheltered housing Stigma	ASSIA BASW CINAHL Iriss Mental Welfare Commission for Scotland SCIE Scopus Scottish Executive Scottish Government Scottish Recovery Network Social Care Online SSKS Web of Knowledge Westlaw